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ABSTRACT

Ten legislative bills related to VA health manpower training and education and to veterans' health care were considered at this hearing. The bills concerned the following: (1) establishment of new public nonprofit medical, health profession, and allied health schools and the expansion and improvement of health manpower training programs in VA facilities and VA-affiliated institutions; (2) improved medical and nursing home care to veterans and to certain survivors and dependents of veterans; improved structural safety of VA facilities; recruitment and retention of career personnel in Dept. of Medicine and Surgery; (3) advanced residency-type training to medical personnel of the VA and other Federal Depts. and Agencies at Regional Medical Centers in VA hospitals; (4) financial assistance to institutions providing programs for training veterans with military acquired medical skills in the allied health professions; (5) pay differentials for VA nursing staff; (6) a rebuttable presumption that a disability of a veteran of any war or certain other military service is service-connected under certain circumstances; (7) the establishment of new State medical school; improvement of VA-affiliated medical schools; development of cooperative arrangements between higher-education institutions, hospitals, public or nonprofit health service institutions, and the VA for conducting educational and training programs for health care personnel; and (8) adjustment by the VA Administrator of the legislative jurisdiction over lands of the U. S. that are under his supervision and control. In addition to the text of each bill, reports of various government agencies, statements of various individuals, article reprints, excerpts of articles letters, tables, and charts are provided. An appendix concerns training of health service personnel in the VA. (DB)

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VA HEALTH CARE AND HEALTH MANPOWER TRAINING LEGISLATION

ED 064570

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND HOSPITALS

OF THE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

NINETY-SECOND CONGRESS

FIRST SESSION

ON

S. 2219, S. 2354, S. 2355, S. 1924, S. 2304, S. 1635, S. 2340, H.J. Res. 748, H.R. 481, and Related Bills

AUGUST 4, 1971

Printed for the use of the Committee on Veterans' Affairs

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CONTENTS

Page

- Opening statement of Hon. Alan Cranston, Chairman of the Subcommittee on Health and Hospitals 1
- Bill S. 2219, as referred to the Committee on Veterans' Affairs:
  - Text of 6
  - Introductory statement of author (Senator Alan Cranston), including statements from Dr. Rheba de Tornyay, Dean of the School of Nursing at the University of California, Los Angeles and letter from Dr. Clifford Grobstein, Dean of the School of Medicine, University of California, San Diego 25
  - Section-by-section analysis of 36
  - Agency reports of:
    - Veterans' Administration, including section-by-section analysis of 40
    - Office of Management and Budget 49
    - Comptroller General of the United States 50
- Bill S. 2354, as referred to the Committee on Veterans' Affairs:
  - Text of 51
  - Introductory statement of author (Senator Alan Cranston) 82
  - Veterans' Administration report of, including section-by-section analysis of 85
- Bill S. 2355, as referred to the Committee on Veterans' Affairs:
  - Text of 112
  - Introductory statement of author (Senator Alan Cranston), including an article written by Dr. E. Grey Dimond, provost for the health sciences, University of Missouri at Kansas City 117
  - Agency reports of:
    - Veterans' Administration 122
    - Office of Management and Budget 124
    - Comptroller General of the United States 124
    - Health, Education, and Welfare 125
- Bill S. 1924, as referred to the Committee on Veterans' Affairs:
  - Text of 126
  - Agency reports of:
    - Veterans' Administration 140
    - Veterans' Administration transmittal letter to the President of the Senate, including section-by-section analysis of 141
    - Comptroller General of the United States 153
- Bill S. 2304, as referred to the Committee on Veterans' Affairs:
  - Text of 154
  - Agency reports of:
    - Veterans' Administration 159
    - Office of Management and Budget 162
- Bill S. 1635, as referred to the Committee on Veterans' Affairs:
  - Text of 163
  - Agency reports of:
    - Veterans' Administration 168
    - Office of Management and Budget 170
- Bill S. 2340, as referred to the Committee on Veterans' Affairs:
  - Text of 171
  - Agency reports of:
    - Veterans' Administration 173
    - Office of Management and Budget 176
- Bill H.J. Res. 748, as referred to the Committee on Veterans' Affairs:
  - Text of 177
  - H. Rept. 92-322, excerpt from 191
  - House agency reports of:
    - Veterans' Administration 194
    - Office of Management and Budget 198

Bill H.J. Res. 748, as referred to the Committee on Veterans' Affairs—Con.

Senate agency reports of:

Page
Veterans' Administration 199
Department of Health, Education and Welfare 203
Office of Management and Budget 206
Comptroller General of the United States 207

Bill H.R. 481, as referred to the Committee on Veterans' Affairs:

Text of 209

Agency reports of:

Veterans' Administration 211
Veterans' Administration transmittal letter to the President of the Senate, with enclosure 212
Office of Management and Budget 214

Statement of—

Dr. Marc J. Musser, Medical Director, Veterans' Administration; accompanied by Dr. Benjamin B. Wells, Deputy Medical Director; John Corcoran, General Counsel; and James Lund, Office of Assistant Administrator for Personnel 214
Dr. Philip R. Lee, chancellor, University of California, School of Medicine, San Francisco, Calif 267
Dr. William G. Anlyan, vice president for health affairs of Duke University, Durham, N.C.; and Mr. Prentice Bowsher, Association of American Colleges 285
Col. Herbert M. Houston, chairman and legislative director, World War I Veterans Legislative Committee; Floyd Henderson, national adjutant; and J. B. Koch, National Commander of Veterans of World War I, U.S.A., Inc 321
Dr. Amos Johnson, past president, American Academy of Family Practice, Garland, N.C 325
William M. Feagans, dean, school of dentistry, State University of New York, Buffalo, N.Y 332
Francis W. Stover, director, national legislative service, Veterans of Foreign Wars of the United States 338
Hon. Frank E. Moss, a United States Senator from the State of Utah 342
Dr. Thomas F. Jones, president, University of South Carolina 344
Dr. David D. Rutstein, Ridley Watts, Professor of Preventive Medicine at Harvard Medical School, Boston, Mass 350
John Grupenhoff, Ph. D., executive secretary, National Committee To Save Our Schools of Health 359
Paul Lowery, superintendent, Des Moines Area Community College, Des Moines, Iowa; accompanied by Nancy Hartley, dean of instruction, health related programs, St. Petersburg Junior College, St. Petersburg, Fla 363
Patrick E. Zembower, associate director in charge of Federal representations, American Nurses Association; accompanied by Betty Coleman and Ra Sedgwick, registered nurses 379
William Samuels, executive director, Association of Schools of Allied Health 396

Written statement of—

Dr. Rheba de Tornyay, Dean of the School of Nursing at the University of California, Los Angeles, Calif 32
Dr. Marc J. Musser, Chief Medical Director, Veterans' Administration 225
Dr. Philip R. Lee, chancellor, School of Medicine, University of California, San Francisco, with enclosure 274
Dr. William G. Anlyan, chairman of the executive council, Association of American Medical Colleges on Veterans' Administration Medical program 316
J. B. Koch, national commander, Veterans of World War I, U.S.A., Inc 323
Dr. Amos Johnson, past president, American Academy of Family Practice, Garland, N.C 329
Dean William A. Feagans, school of dentistry, State University of New York, Buffalo, N.Y 336
Francis W. Stover, director, national legislative service, V.F.W 340

Written statement of—Continued

Page
- Dr. Thomas F. Jones, president, University of South Carolina 348
- John T. Grupenhoff, Ph. D., executive secretary, National Committee To Save Our Schools of Health 360
- Paul J. Lowery, superintendent, Des Moines Area Community College, Des Moines, Iowa 369
- Nancy Hartley, dean of instruction, health related programs, St. Petersburg Junior College, St. Petersburg, Fla 371
- Patrick E. Zembower, Federal representative, American Nurses' Association 381
- William Samuels, executive director, Association of Schools of Allied Health Professions 396
- Hon. John G. Tower, a U.S. Senator from the State of Texas 398
- Hon. Ernest F. Hollings, a U.S. Senator from the State of South Carolina 403
- E. H. Golembieski, director, Veterans Affairs and Rehabilitation Commission, the American Legion 404
- Dr. V. Eugene McCrary, chairman of Federal Legislation Committee, American Optometric Association 410
- Dr. George James, president, Mount Sinai Medical Center and dean, Mount Sinai School of Medicine, New York City 413
- The American Medical Association 415
- American Dental Association and American Association of Dental Schools 418

Miscellaneous—

- A National Graduate Medical Center, an article written by Dr. E. Grey Dimond, provost for the health sciences, University of Missouri at Kansas City 118
- Summary of education and training activities of department of medicine and surgery for fiscal year 1971 et seq 236
- Excerpts from the Carnegie Commission Report 246
- A preliminary proposal for the development of area health education centers using Veterans' Administration facilities as the core of such a cooperative endeavor 253
- The Multi-Modality Narcotics and Drug Abuse Program for Veterans Proposed To Begin Development on July 1, 1971, an article written by Dr. Arnold J. Mandell, VAH, San Diego 278
- Total employee participation (PEP) 286
- Financial aid notes (PEP) 289
- Paths for Employee Progress (Duke University Medical Center) 290
- El Centro College, Dallas, Tex.—Civilian RN to army medic, navy corpsman, and air force technician 376
- Opinion—Profession of Unlimited Potential, an article from the American Journal of Nursing, July 1971, written by Nathan Hershey, president, American Hospital Association's Society of Hospital Attorneys 388

Letters to—

Hon. Alan Cranston, chairman, Subcommittee on Health and Hospitals of the Committee on Veterans' Affairs, from:

- Clifford Grobstein, vice chancellor for health sciences and dean of the school of medicine, University of California, San Diego, La Jolla, Calif., dated June 7, 1971 34
- Patrick E. Zembower, associate director in charge of Federal representation, American Nurses' Association, Inc., New York, N.Y., dated January 7, 1972 394
- Charles L. Huber, national director of legislation, Disabled American Veterans, dated August 6, 1971 421
- Michael W. Burns, executive director, Paralyzed Veterans of America, Inc., dated August 19, 1971 422
- Frank Reissman, director, and Alan Gartner, associate director, new careers training laboratory, New York University, New York, N.Y., dated September 2, 1971 423
- Dr. Michael E. De Bakey, Baylor College of Medicine, Houston, Tex., dated Dec. 3, 1971 424

Hon. Vance Hartke, chairman, Committee on Veterans' Affairs, from N. T. Wolkomir, president, National Federation of Federal Employees, Washington, D.C., dated Jan. 24, 1972 424

Tables—

Page
Possible use of $125,000,000 under new chapter 82 in S. 2219 per year over 6 years for various purposes, etc 34
Allocation of construction costs for new schools, etc 35
Schedule for opening of new schools, etc 35
Projected enrollment for new schools under subchapter III of chapter 82:
  Table A—Medical and dental schools will have 50-student classes, etc 35
  Table B—Nursing school (4-year) would accept an initial entering class of 50 students in the 2d program year, etc 35
Carnegie commission goals for new university health science centers by 1980 246
University health science centers and Carnegie commission goals for new university health science centers and area health education centers by 1980, by State 249
Cardiac surgery centers 266
Distribution by institution and area of study for present PEP employee-students with projected graduation dates 287
Distribution by educational programs requested 287
Job progressions for graduates (PEP) 288
Sex and race distribution (PEP) 288
ANA proposed nurse salary schedule 383
Basic requirements for appointment and promotion to nurse positions 384
A comparison of the proposed nurse schedules 384
Comparison of premium pay benefits 385
Linkage—proposed pay schedules in S. 2354 385
Veterans' Administration requirements for appointment to full grade 385
Civil service qualification standards for GS-7 and GS-9 physicians assistants 385
Premium pay benefits in selected ANA collective agreements, September 1971 392
General duty nurses—premium pay for evening shift comparative by district, average monthly premium pay for 3 to 11 P.M. shift (State and Federal hospitals excluded) 394

Charts—

The hospital of the future 353
Regional system 354
Ambulatory care 354
Districts of the Illinois Hospital Association 393

APPENDIX

Appendix A.—Training of health service personnel in the Veterans' Administration (House Committee Print No. 3) 427

VA HEALTH CARE AND MANPOWER TRAINING LEGISLATION

WEDNESDAY, AUGUST 4, 1971

U.S. Senate,
Subcommittee on Health and Hospitals of the
Committee on Veterans' Affairs,
Washington, D.C.

The subcommittee met at 9 a.m., pursuant to call, in room 6202, New Senate Office Building, Senator Alan Cranston (chairman of the subcommittee) presiding.

Present: Senators Cranston and Hansen.

OPENING STATEMENT OF HON. ALAN CRANSTON, CHAIRMAN OF THE SUBCOMMITTEE ON HEALTH AND HOSPITALS

Senator Cranston. The hearing will come to order.

I thank each of you for your interest and your presence. I will make a brief opening statement and then we will proceed to hearing the witnesses.

Today, the Health and Hospitals Subcommittee will receive testimony from 14 witnesses who are broadly representative of groups involved in the provision of veterans health care and the education and training of health manpower in conjunction with Veterans' Administration hospitals. We plan to take a brief recess for lunch and reconvene these hearings at 1:30 this afternoon.

In addition to those witnesses from whom we will receive testimony today, prepared statements will be submitted for the record by the American Legion, AMVETS, American Veterans Committee, Disabled American Veterans, and the Paralyzed Veterans of America. We also expect to receive statements from several Senators and some distinguished members of the medical community who were unable to arrange their schedules to be with us today.

Without objection, following my statement I will insert in the record the bills under consideration at this hearing, appropriate introductory statements regarding those bills, along with other pertinent descriptive material, and the agency reports on each bill.

The bills under consideration today fall roughly into two major categories: Veterans' Administration health manpower training and education legislation, and veterans health care legislation.

These hearings will also cover a third miscellaneous category involving H.R. 481, an administration bill, which has passed the House, relating to the ceding of jurisdiction of certain Veterans' Administration lands and facilities to the State in which they are located. I have had some reservations about the broad nature of the language in the administration proposed bill, particularly the notion of relinguishment of Federal legislative jurisdiction over such lands and facilities. On the other hand, I do support the general principle involved and would be much more favorably inclined toward a generic bill patterned after Public Law 91-45, which I had the privilege to manage through the Senate, and which ceded to the State of Montana concurrent jurisdiction over the real property comprising the VA center at Fort Harrison, Mont. I feel sure that we can work these matters out in cooperation with the Veterans' Administration.

VA Health Manpower Training and Education Bills

There are two principal bills under consideration in this category: the House-passed bill, House Joint Resolution 748, authored by my good friend Olin E. Teague, chairman of the House Veterans' Affairs Committee, and my bill, S. 2219, the proposed "Veterans' Administration Health Manpower Training Act of 1971," which is cosponsored by a distinguished bipartisan group of Senators, including the distinguished majority leader. There are also three related bills in this category, Senate Joint Resolution 76, Senate Joint Resolution 126, and S. 2304.

The two principal bills under consideration in this area share a common purpose and direction. Indeed, I am indebted to the leadership of Chairman Teague in this area and hope that in S. 2219 we have made certain modifications which will serve to strengthen the approach of this important legislation. The basic purpose is to utilize to the fullest extent the capacity of Veterans' Administration hospitals and other health facilities for the training and education of physicians, dentists, nurses, other health professionals, allied health professionals, and paraprofessional and other health manpower.

I wish to stress that included in S. 2219 are provisions emphasizing the training of new types of health personnel such as physicians' assistants, dentists' assistants and nurse practitioners. A similar emphasis is included in S. 2354, which I shall describe shortly and in amendments I proposed, adopted by the Senate to S. 934 and S. 1747, the health professions and nursing education bills now pending in conference committee.

I have long felt that the Veterans' Administration is in a unique position to be of enormous influence in the innovation and development of new methods of training with respect to new categories of health personnel. It is my hope that VA hospitals around this country, unfettered by the strictures of often outdated and rigid State licensing laws and practices, can assume an aggressive leadership in this field. As well as contributing to long overdue advancement in methods of providing health care, such training and education activities by the Veterans' Administration would undoubtedly improve the quality and quantity of the health services provided to individual disabled veterans. Finally, such new and expanded VA programs would provide for the first time a coordinated and unitary system to make maximum use of the largely wasted potential of the tens of thousands of men released from military service each year—and many times that number who have long since been discharged—who have received training in a military occupational speciality in the health field, particularly those who served as medical corpsmen.

S. 2219 would authorize the appropriation of $125 million annually for the next 6 fiscal years for three basic purposes:

1. It would authorize the VA to expand its own hospital education and training capacity through remodeling and renovation of existing facilities to provide for expanded education programs as well as to make special allocations to particular VA hospitals to develop or develop and initiate programs for improved methods of education and training.

2. It would authorize the VA to make grants to public colleges and universities to assist in the establishment of up to ten new health professions and allied health schools or area health education centers.

The assistance under this chapter would include the leasing cost-free to the college or university of VA hospital and other health facilities; the remodeling and extension of such facilities when necessary to make them suitable for such educational purposes; and reimbursement of the costs of faculty salaries for the first 6 years of the operation of the new school or center—90 percent for the first three years and 50 percent for the second 3 years of operation. I wish to stress with regard to grants for the establishment of new schools or area health education centers that I have attempted to include in my bill, after consultation with appropriate individuals in the health education field, provisions to ensure the maintenance of high standards both of education and the provision of health care in such facilities, including appropriate consultation with the Secretary of Health, Education, and Welfare and academic accreditating bodies.

3. It would authorize the VA to make grants to any nonprofit health professions, allied health or other health personnel training institution or area health education center which maintains a teaching affiliation with the VA Department of Medicine and Surgery, for the purpose of expanding and improving the capacity of those institutions to train health manpower. Such grants would include remodeling and extension of existing education facilities at such institutions, but could not include construction of new free-standing facilities. Again, provision has been made for appropriate consultation with the Secretary of HEW and for receiving reasonable assurance from recognized academic accrediting bodies with respect to any substantial increases in the number of trainees.

In this general area, we also have under consideration my bill, S. 2355, which is the proposed Continuing Medical Education Act, under which the VA would be directed to establish four geographically dispersed regional medical education centers to provide in-residence continuing medical education and refresher training to VA personnel and, on a reimbursable basis, health personnel from other Federal agencies as well as the surrounding community.

VETERANS HEALTH CARE LEGISLATION

The two major bills under consideration in this area are my bill, S. 2354, the proposed Veterans Health Care Reform Act of 1971, and S. 1924, the administration bill, the proposed Veterans Medical Care Act of 1971, which I was pleased to introduce, by request, along with Chairman Hartke and the ranking minority member, Senator Thurmond, of the Veterans' Affairs Committee.

S. 2354 incorporates and expands and, I believe, improves upon virtually every provision recommended by the administration in its bill, S. 1924. In addition, this proposed Veterans Health Care Reform Act of 1971 has the following features:

(1) It would require that every VA facility reach a comparable staff-to-patient ratio with local community hospitals within 3 years. Present ratios are 1.5 to 1 at a VA general hospital; 2.7 to 1 at the average community hospital and up to 4 to 1 at a university hospital.

(2) It would bring family members into a veterans treatment and rehabilitation program; expand home health care programs; and open VA medical facilities, as well as contract care, to dependents of permanent and totally disabled veterans and direct VA care to survivors receiving disability and indemnity compensation. Total health care of a veteran often requires treating the individual as part of a family unit, not in isolation.

(3) It would authorize full inpatient and outpatient treatment of non-service-connected conditions for eligible veterans and dependents. The bill would thus make it easier for a veteran needing prompt medical attention to receive it promptly regardless of service connection.

(4) It would enable veterans to obtain direct admission to a VA nursing home without first having to be hospitalized; authorize direct patient transfers from a military hospital to a VA nursing facility; and raise the statutory minimum of 4,000 VA nursing home beds to 10,000 by fiscal 1974. The bill calls for converting hospital beds into nursing home beds where they are not being fully utilized.

(5) It would authorize the VA to pay special salary differentials in both high-cost areas and at remote hospitals for medical posts they have difficulty filling; peg salaries to those paid by other hospitals in the community; and, similar to the administration bill, pay overtime and premium pay for all nursing personnel, and permit other hospitals, clinics, or medical schools to use excess VA hospital beds.

(6) It would revise and expand the Department of Medicine and Surgery's health care personnel authorities to place all VA health personnel, including licensed practical nurses, nursing assistants and aides, technologists, technicians, and other scientific and allied health personnel and physicians' and dentists' assistants, directly under the Department of Medicine and Surgery, rather than the Civil Service. This should provide substantially greater flexibility in running the VA health care system, increase recruitment and retention of personnel, and thus improve patient care.

(7) It would require that VA medical facilities be made fireproof and resistant to earthquakes and other natural disasters, and that patients be reimbursed for personal effects destroyed by disasters other than fire. This provision is motivated by the recent tragic losses of lives at various veterans hospitals because of the disastrous earthquake in my State at San Fernando, Calif., and a tornado at Fayetteville, N.C. There was also extensive property loss and damage at VA facilities at Gulfport and Biloxi, Miss., because of Hurricane Camille 2 years ago.

In addition, we will consider in this veterans health care area, S. 2340, which I recently introduced on behalf of Senator Montoya and myself in the same form in which it passed the Senate as S. 1279 last Congress. This bill deals with former prisoners of war and others whose military medical records are unavailable or were destroyed and who require medical care.

On Monday of this week, the Senate approved the conference report on H.R. 9382, the Department of Housing and Urban Development, Space, Science, Veterans, and certain other Independent Agencies appropriation bill for fiscal year 1972, appropriating $204.1 million more for the VA hospital and medical program than was requested in the President's original budget. When added to the $163 million which we appropriated above the President's original budget last fiscal year—for a total increase of $367.1 million, over a 2-year period—I believe we have provided the VA with a stabilized financial base.

Thus, as we open these hearings and begin to consider the comprehensive legislative proposals before us, it is our task to reevaluate and rethink basic VA hospital and enabling legislation, and to revise and reform it as necessary to enable this enormous, largest single hospital and medical program in this country to move forward to provide quality care to all eligible veterans and, in appropriate cases, their eligible dependents. Thus, we are entering a second phase in the work we seek to accomplish in regard to veterans' care.

Before hearing from the Veterans' Administration this morning, I wish to pay tribute to the outstanding leadership which the Department of Medicine and Surgery has had during the last several years under Drs. Marc J. Musser and Benjamin B. Wells, the Chief and Deputy Chief Medical Director. I fully realize that, as they present their testimony this morning, the words they will be speaking will be those of the Office of Management and Budget and not those that they wish, based on their high professional qualifications, sound medical judgment, and extensive experience in the VA health care program, to bring to our deliberations today.

That concludes my statement. I feel as if I were the first witness. I apologize for going on at such length, but I felt it important to set out the broad outlines of what we want to accomplish. We hope that the witnesses that will be with us today, from their backgrounds and knowledge, will present testimony of great benefit to us in considering this broad range of legislation. This can be significant legislation in terms of the great impact it can have on both VA hospitals and beyond that, on health care generally in America, because of the impact that accomplishments in VA can have on medical care generally in our country. So we consider these hearings of great importance, and your aid to us in these hearings is of great importance.

I know that my good friend and colleague from West Virginia, Senator Randolph, who served with great distinction as chairman of the former Veterans' Affairs Subcommittee of the Labor and Public Welfare Committee wanted very much to be with us this morning but was unable to do so because of a scheduling conflict.

He has discussed with me the legislation before us, is an original cosponsor of S. 2219, and is anxious to study the testimony given today on this legislation. He has asked me to keep him closely advised of developments today and in the future on these bills. I intend to do so and to seek his wise counsel and support as we prepare these measures for subcommittee and full committee action.

(The text of bills previously referred to, including agency reports thereon, follows:)

92D CONGRESS
1ST SESSION

S. 2219

IN THE SENATE OF THE UNITED STATES

JUNE 30, 1971

Mr. CRANSTON (for himself, Mr. BENTSEN, Mr. EAGLETON, Mr. HUGHES, Mr. MANSFIELD, Mr. MONDALE, Mr. NELSON, Mr. RANDOLPH, and Mr. WILLIAMS) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38 of the United States Code to authorize the Administrator of Veterans' Affairs to provide certain assistance in the establishment of new public nonprofit medical, health professions, and allied health schools and the expansion and improvement of health manpower training programs in Veterans' Administration facilities and in existing educational institutions affiliated with the Veterans' Administration.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Veterans' Administration Health Manpower Training Act of 1971".

SEC. 2. The Congress hereby finds and declares—

II

(1) that there is a great shortage of physicians, other health professionals, allied health personnel, and other health manpower in the United States;

(2) that it is estimated that there is a shortage in the United States now of at least forty-eight thousand physicians, seventeen thousand eight hundred dentists, one hundred fifty thousand nurses, eight thousand seven hundred optometrists, twelve thousand nine hundred podiatrists, and two hundred sixty-six thousand allied health and other health personnel;

(3) that the Veterans' Administration operates the largest medical care system in the United States with over a quarter century of experience in the education and training of health manpower;

(4) that the Department of Medicine and Surgery of the Veterans' Administration maintains an active and close affiliation with eighty-one medical schools, fifty-one dental schools, two hundred and eighty-seven schools of nursing and approximately four hundred universities, colleges, and junior colleges which educate and train health manpower;

(5) that it is essential that the health manpower pool of the Nation be expanded;

(6) that if the training of sufficient numbers of physicians, other health professionals, allied health per-

sonnel, and other health personnel is to be accomplished, it is essential that the educational capacities of medical and health professions schools affiliated with the Veterans' Administration be expanded, that new medical and health professions schools affiliated with Veterans' Administration hospitals be established, and that education and training opportunities for the training of existing and future allied health and other health personnel be expanded and improved;

(7) that because of the size, diversity, and quality of its medical program, the Veterans' Administration's Department of Medicine and Surgery is uniquely qualified to assist in the expansion and improvement of existing affiliated medical, other health professions and allied health schools and area health education centers, in the establishment of new public nonprofit medical, health professions and allied health schools and area health education centers, and in the expansion and improvement of education and training opportunities for allied health and other health personnel; and

(8) that it is essential that an adequate number of physicians, health professionals, allied health personnel, and other health personnel be trained if the Congress is to discharge its responsibility to provide the best possible medical care for the Nation's veterans.

SEC. 3. Section 4101 of title 38, United States Code, is amended by deleting subsection (b) and inserting in lieu thereof the following:

"(b) In order to carry out more effectively the primary function of the Department of Medicine and Surgery to provide a complete medical and hospital service for the medical care and treatment of veterans and to assist in providing an adequate supply of health manpower to the Nation, the Administrator shall, to the extent feasible without interfering with the medical care and treatment of veterans, develop and carry out a program of education and training of such health manpower, acting in cooperation with such schools of medicine, osteopathy, dentistry, nursing, pharmacy, optometry, podiatry, public health or allied health professions; other institutions of higher learning; medical centers; academic health centers and area health education centers; hospitals; and such other public or nonprofit agencies, institutions, or organizations as the Administrator deems appropriate. For the fiscal year ending June 30, 1972, and for each fiscal year thereafter, there shall be included in the budget required to be submitted to Congress by section 201 of the Budget and Accounting Act, 1921 (31 U.S.C. 11) a separate line item showing the estimated expenditures by the Veterans' Administration during such fiscal year for the education and training of health manpower."

SEC. 4. Section 5001 (c) of title 38, United States Code, is amended by striking out the period at the end of such section and inserting in lieu thereof a comma and the following: "except that any new hospital shall be constructed in close proximity to a school of medicine or osteopathy which is accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education of the Department of Health, Education, and Welfare and which has agreed to affiliate with the Veterans' Administration through such hospital and shall include such classrooms, lecture facilities, laboratories, and other teaching space, facilities, aids, and beds as are necessary to make the hospital suitable for health manpower education and training in accordance with the purposes of chapter 82 of this title".

SEC. 5. (a) Part VI of title 38, United States Code, is amended by inserting immediately after chapter 81 the following new chapter:

"Chapter 82—UTILIZATION OF VETERANS' ADMINISTRATION HOSPITALS TO IMPROVE AND EXPAND EDUCATION AND TRAINING OF HEALTH MANPOWER

"SUBCHAPTER I—COORDINATION WITH OTHER PROGRAMS; AUTHORIZATIONS FOR APPROPRIATIONS; GENERAL PROVISIONS

"Sec.
"5061. Coordination with other programs.
"5062. Authorization for appropriations.
"5063. Limitation on agreements; regulations.

"SUBCHAPTER II—EXPANSION OF VETERANS' ADMINISTRATION HOSPITAL EDUCATION AND TRAINING CAPACITY

"5064. Expenditures to remodel and make special allocations to Veterans' Administration hospitals for health, manpower education, and training.

"SUBCHAPTER III—PILOT PROGRAM FOR ASSISTANCE IN THE ESTABLISHMENT OF NEW PUBLIC NONPROFIT MEDICAL, HEALTH PROFESSIONS, AND ALLIED HEALTH SCHOOLS AND AREA HEALTH EDUCATION CENTERS

"5065. Declaration of purpose.
"5066. Definitions.
"5067. Pilot program assistance.

"SUBCHAPTER IV—ASSISTANCE TO AFFILIATED MEDICAL, HEALTH PROFESSIONS, AND ALLIED HEALTH SCHOOLS AND OTHER HEALTH MANPOWER TRAINING INSTITUTIONS, AND AREA HEALTH EDUCATION CENTERS

"5071. Declaration of purpose.
"5072. Definitions.
"5073. Grants.
"5074. Payments.

"SUBCHAPTER I—COORDINATION WITH OTHER PROGRAMS; AUTHORIZATIONS FOR APPROPRIATIONS; GENERAL PROVISIONS

"§ 5061. Coordination with other programs

"The Administrator and the Secretary of Health, Education, and Welfare shall, to the maximum extent practicable, coordinate programs carried out under this chapter and programs carried out under section 309 and titles VII, VIII, and IX of the Public Health Service Act.

"§ 5062. Authorization for appropriations

"There is hereby authorized to be appropriated $125,000,000 for the fiscal year ending June 30, 1972, and a like sum for each of the five succeeding fiscal years. Funds appropriated pursuant to this section shall be used for entering into agreements and making grants pursuant to this chapter. Funds appropriated pursuant to this section shall remain available until expended. Not more than 2 per centum of the funds appropriated pursuant to this section for any fiscal year may be used for administrative expenses in carrying out this chapter in such fiscal year.

"§ 5063. Limitations on agreements; regulations

"(a) The Administrator may not enter into any agreement under subchapter III of this chapter or make any grant under subchapter IV of this chapter after the close of the sixth calendar year after the calendar year in which this chapter takes effect.

"(b) The Administrator may not enter into any agreement under subchapter III of this chapter or make any grant under subchapter IV of this chapter without prior consultation with an Advisory Subcommittee on Programs for Assistance for Health Manpower Education and Training, which the Administrator is hereby authorized to establish, of the Special Medical Advisory Group established under section 4112 of this title. The Assistant Chief Medical Director for Research and Education in Medicine shall be an ex officio member of such subcommittee.

"(c) The Administrator shall ensure that qualified persons who have been separated or discharged from the active military, naval or air service shall be given priority for admission to health manpower education and training programs assisted under this chapter or any other provision of this title and that among such qualified persons those who served during the Vietnam era and those who are entitled to disability compensation under laws administered by the Veterans' Administration or whose discharge or release was for a disability incurred or aggravated in line of duty shall be given the highest priority.

"(d) The Administrator, after consultation with the advisory subcommittee referred to in subsection (b) of this section, shall prescribe regulations covering the terms and conditions for entering into agreements under subchapter III and making grants under subchapter IV of this chapter.

SUBCHAPTER II—EXPANSION OF VETERANS' ADMINISTRATION HOSPITAL EDUCATION AND TRAINING CAPACITY

"§ 5064. Expenditures to remodel and make special allocations to Veterans' Administration hospitals for health manpower education and training

"Out of funds appropriated to the Veterans' Administration pursuant to the authorization in section 5062 of this title, the Administrator may expend such sums as he deems necessary, not to exceed 30 per centum thereof, for (A) the necessary extension, expansion, alteration, improvement, remodeling, or repair of Veterans' Administration buildings and structures (including provision of initial equipment, replacement of obsolete or worn-out equipment, and, where necessary, addition of classrooms, lecture facilities, laboratories, and other teaching space, facilities, aids, and beds) to the extent necessary to make them suitable for use for health manpower education and training in order to carry out the purpose set forth in section 4101 (b), and (B) special allocations (including trainee stipends and instruction salaries) to Veterans' Administration hospitals for the development or initiation of improved methods of education and training which may include the development or initiation of plans which reduce the period of required education and training for health personnel but which do not adversely affect the quality of such education or training.

"SUBCHAPTER III—PILOT PROGRAM FOR ASSISTANCE IN THE ESTABLISHMENT OF NEW PUBLIC NONPROFIT MEDICAL, HEALTH PROFESSIONS, AND ALLIED HEALTH SCHOOLS AND AREA HEALTH EDUCATION CENTERS

"§ 5065. Declaration of purpose

"The purpose of this subchapter is to authorize the Administrator, in consultation with the Secretary of Health, Education, and Welfare, to implement a pilot program under which he may provide assistance in the establishment of new public nonprofit health professions and allied health schools, and area health education centers if such schools and centers are located in proximity to, and operated in conjunction with, Veterans' Administration medical facilities.

"§ 5066. Definitions

"For the purpose of this subchapter—

"(1) The term 'area health education center' means a public nonprofit educational facility or other public nonprofit institution affiliated with a Veterans' Administration hospital for the conduct of or the providing of guidance for education and training programs for health manpower in association with State, community, or other nonprofit colleges or universities, other hospitals and health facilities, or professional health or medical organizations in a particular geographical area to serve as an instrument of cooperation between the medical school and its education, research, and health service programs and the framework of health facilities and organizations and activities for the betterment of health in a given area.

"(2) The term 'health professions school' includes any public nonprofit school of medicine, osteopathy, dentistry, nursing, pharmacy, optometry, podiatry or public health which is, or there is reasonable assurance will be, accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education of the Department of Health, Education, and Welfare.

"(3) The term 'State' means the several States, the District of Columbia, and the Commonwealth of Puerto Rico.

"§ 5067. Pilot program assistance

"(a) Subject to subsection (b) of this section, the Administrator, in consultation with the Secretary of Health, Education, and Welfare, may enter into an agreement to provide to any public nonprofit college or university the following assistance to enable such college or university to establish a new health professions or allied health school or an area health education center:

"(1) The leasing to the college or university for nominal or no consideration, under such terms and conditions as the Administrator deems appropriate, of such land, and such buildings and other structures (including equipment therein) under the control and jurisdiction of the Veterans' Administration as may be necessary for the establishment and operation of such school or center. Any lease made pursuant to this subchapter to any public or nonprofit organization may be made without regard to the provisions of section 3709 of the Revised Statutes (41 U.S.C. 5). Notwithstanding section 321 of the Act entitled "An Act making appropriations for the Legislative Branch of the Government for the fiscal year ending June 30, 1933, and for other purposes", approved June 30, 1932 (40 U.S.C. 303b), or any other provision of law, a lease made pursuant to this subchapter to any public nonprofit organization may provide for the maintenance, protection, or restoration, by the lessee, of the property leased, as a part or all of the consideration for the lease.

"(2) The extension, alteration, improvement, remodeling, or repair of buildings and structures (including the provision of initial equipment, and replacement of obsolete or worn-out equipment) and, where necessary, the addition of hospital teaching beds provided under paragraph (1) to the extent necessary to make them suitable for use as health professions schools or area health education center facilities.

"(3) The payment of grants to reimburse the college or university in part for the cost of the salaries of the faculty of such school or center during the initial twelve-month period of operation of the school or center and the next five such twelve-month periods, but payment under this paragraph in the case of any college or university shall not exceed an amount equal to—

"(A) 90 per centum of the cost of faculty salaries during the first three twelve-month periods of operation, and

"(B) 50 per centum of such cost during the second such three twelve-month periods.

"(b) (1) The Administrator may not enter into any agreement under subsection (a) of this section unless he finds that—

"(A) the college or university has declared its clear intention, and submitted to the Administrator a plan under which it agrees, to provide during the term of the agreement its share of the financial support for the proposed school or center, including full financial support for all other educational programs and facilities necessary to assure compliance with the provisions of clause (D) of this paragraph and to provide full salary support for the proposed school or center thereafter;

"(B) the overall plans for the school or center meet such professional and other standards as the Administrator deems appropriate in consultation with the Secretary of Health, Education, and Welfare as to the education and training programs and include significant programs for (i) cooperative interdisciplinary training among health professions and allied health schools with emphasis on the use of the team approach in providing health services, (ii) training for new roles, types, or levels of health manpower, including training of physicians', dentists', or other health professions' assistants and of nurse practitioners, providing the fullest opportunities for career advancement and mobility, or (iii) recruiting, enrolling, and retraining qualified individuals who due to socioeconomic factors are financially or educationally disadvantaged;

"(C) the school or center will maintain such arrangements with the Veterans' Administration medical facility with which it is associated (including but not limited to such arrangements as may be made under subchapter IV of chapter 81 of this title) as will be mutually beneficial in the carrying out of the mission of the medical facility and the school or center; and

"(D) with regard to health professions and allied health schools, after consultation with the appropriate accreditation body or bodies approved for such purpose by the Commissioner of Education of the Department of Health, Education, and Welfare, there is reasonable assurance that, with the aid of an agreement under subsection (a) of this section, such school will meet the accreditation standards of such body or bodies within a reasonable time.

"(2) Any agreement entered into by the Administrator under this subchapter shall contain such terms and conditions (in addition to those imposed pursuant to subsections (a) (1) and (b) (1) of this section) as he deems necessary and appropriate to protect the interest of the United States.

"(c) The Administrator shall not use the authority under this subchapter to assist in the establishment of more than ten new public nonprofit health professions and allied health schools and area health education centers. Schools and centers established with assistance under this subchapter shall be located in geographically dispersed areas of the United States.

"SUBCHAPTER IV—ASSISTANCE TO AFFILIATED MEDICAL, HEALTH PROFESSIONS, AND ALLIED HEALTH SCHOOLS AND OTHER HEALTH MANPOWER TRAINING INSTITUTIONS, AND AREA HEALTH EDUCATION CENTERS

"§ 5071. Declaration of purpose

"The purpose of this subchapter is to authorize the Administrator in consultation with the Secretary of Health, Education, and Welfare, to carry out a program of grants for eligible health manpower training institutions and area health education centers which maintain affiliations with the Veterans' Administration in order to assist such institutions or centers to expand and improve their capacities to train health manpower.

"§ 5072. Definitions

"For the purpose of this subchapter, the term 'eligible institution' means any public or private nonprofit—

"(1) health professions school of the type defined in section 5066(b) of this title, "(2) area health education center of the type defined in section 5066(a) of this title, or

"(3) institution for the training or education of allied health or other health personnel,

which maintains an affiliation with the Veterans' Administration.

"§ 5073. Grants

"(a) Any eligible institution may apply to the Administrator for a grant under this subchapter to assist such institution to carry out, through the Veterans' Administration hospital with which it is affiliated, projects and programs for the expansion and improvement of such institution's capacity to train health manpower. Any such application shall contain a plan to carry out such projects and programs and such other information in such detail as the Administrator deems necessary and appropriate. Grants under this subchapter which provide for the construction of facilities may include only the extension, expansion, alteration, improvement, remodeling or repair of existing structures (including provision of initial equipment and replacement of obsolete or worn-out equipment).

"(b) An application for a grant under this section may be approved by the Administrator, in consultation with the Secretary of Health, Education, and Welfare, only upon the Administrator's finding that—

"(1) the proposed projects and programs for which the grant will be made will make a significant contribution to improving the education (including continuing education) or training program of the eligible institution and will result in a substantial increase in the number of students trained at such institution;

"(2) there is reasonable assurance from a recognized accrediting body or bodies approved for such purposes by the Commissioner of Education of the Department of Health, Education, and Welfare that the increase in the number of students will not threaten any existing accreditation or otherwise compromise the quality of the training at that institution;

"(3) the application sets forth such fiscal control and accounting procedures as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this subchapter;

"(4) the application provides for making such reports, in such form and containing such information, as the Administrator may require to carry out his functions under this subchapter, and for keeping such records and for affording such access thereto as the Administrator may find necessary to assure the correctness and verification of such reports; and

"(5) the application sets forth significant programs for the education and training of physicians', dentists', and other health professions' assistants, nurse practitioners, and other new types of health personnel, providing the fullest opportunities for career advancement and mobility.

"§ 5074. Payments

"Payments made pursuant to grants under this subchapter may be made in installments, and in advance or by way of reimbursement in installments, and in advance or by way of reimbursement with necessary adjustments on account of overpayments or underpayments, as the Administrator may determine."

(b) The table of parts and chapters at the beginning of title 38, United States Code, and the table of chapters at the beginning of part VI of such title are each amended by adding

"82. Utilization of Veterans' Administration Hospitals to Improve and Expand Education and Training of Health Manpower.. 5060"

immediately below

"81. Acquisition and Operation of Hospital and Domiciliary Facilities; Procurement and Supply........................ 5001".

SEC. 6. During the two-year period immediately following the date of the enactment of this Act, no part of any real property which is under the jurisdiction of the Administrator of Veterans' Affairs on the date of enactment of this

Act shall be determined to be excess to the needs of the Veterans' Administration or transferred or otherwise disposed of pursuant to any provision of the Federal Property and Administrative Services Act of 1949.

[From the Congressional Record—Senate—Thursday, July 22, 1971]

S. 2219: VA HEALTH MANPOWER TRAINING ACT

Mr. CRANSTON. Mr. President, on June 30, 1971, I introduced S. 2219, the proposed Veterans' Administration Health Manpower Training Act of 1971, a bill to amend title 38 of the United States Code to authorize the Administrator of Veterans' Affairs to provide certain assistance in the establishment of new public nonprofit medical, other health professions, and allied health schools and the expansion and improvement of health manpower training programs in Veterans' Administration facilities and in existing educational institutions affiliated with the Veterans' Administration.

At that time, I was unable to make a full statement explaining the bill or present a section-by-section analysis of the bill. I would like to do so at this time.

THE NEED

The Nation's critical shortage of all types of health professionals and all types of allied health professionals is an accepted fact. This shortage is further aggravated by the enormous increase in the use of health care services which can be attributed to our expanding population, increasing numbers of older people and children, better education with a consequent growing awareness of the lack of availability of health care services, and the improved ability of people to pay for health services, especially through the mechanisms of insurance and prepayment.

Among our social goals, few have higher priority than the improvement of public health. I am committed to the proposition that preventive, curative and rehabilitative medical care should be within the reach of all persons in America, regardless of race, geographic location or economic status.

Along with a growing demand for health care services and our efforts to meet this demand, we have experienced an ever increasing sophistication of methods and a relative shortage of skilled manpower in the field. As a consequence, the cost of medical care has risen to a point where it threatens to frustrate our social goals and to price itself beyond the reach of both public and private resources.

THE STATE AND NATURE OF HEALTH MANPOWER EDUCATION AND TRAINING

We have a great deal of knowledge and experience in the field of health manpower development. Indeed, the current health manpower shortage is a reflection of success as well as one of failure. The methods of modern medicine have prevented or cured many of the most devastating of diseases; they have prolonged life, reduced disability and relieved much human suffering. These achievements, along with the inability or unwillingness of health care providers to alter the traditional methods of providing services, have contributed significantly to a demand that now outstrips our ability to render the services needed.

Our need for health manpower goes beyond a mere increase in the numbers of workers. More highly trained personnel must be produced to handle the complex technologies of modern medicine. New categories of workers are needed to extend the functions of existing skills and to achieve the necessary volume of services. Health facilities, human skills, and financing mechanisms must be reexamined and reorganized into new and better methods for the provision of health care. Moreover, in order to retain and update the knowledge and skills of health manpower, we must produce an extensive system of continuing education together with an adequate system for periodic evaluation of both quality and productivity.

I plan to introduce legislation in the near future which will be directly applicable to these latter needs, particularly in the context of Veterans' Administration facilities and health manpower.

ALTERNATIVES TO MEET THE NEED

IMPROVEMENT AND EXPANSION OF MEDICAL SCHOOLS

Many new approaches which I believe show great promise were included in the October 1970 report of the Carnegie Commission on Higher Education. Many of the Commission's recommendations having direct application to expansion and improvement of medical schools have been adopted by the Senate in S. 934, the Health Professions Educational Assistance Amendments of 1971. This bill, which I cosponsored and to which I successfully offered significant amendments, was passed unanimously by the Senate on July 14. My amendments included provisions for the acceleration of medical and dental education, for increases in the size of health professions schools entering classes and for the shortening and reform of required medical school curriculums, as well as incentives to encourage the admission of socioeconomically disadvantaged persons and minority group members to training in medicine and dentistry and the other health professions. I might add, the Senate has also just passed unanimously S. 1747, the Nurse Training Amendments of 1971, which provides these same improvements and advances in the nursing professions. S. 934 also specifically provides for the development of new medical schools.

ESTABLISHMENT OF UNIVERSITY HEALTH SCIENCE CENTERS

The Carnegie Commission also recommended the establishment of additional university health science centers. These centers' responsibilities would include the coordination of the education of health care personnel and cooperation with other community agencies in improving the organization of the provision of health care.

The commission recommended that VA hospitals at Fresno, Calif., Hampton, Va., and at Reno, Nev., be utilized in the establishment of new university health science centers.

ESTABLISHMENT OF AREA HEALTH EDUCATION CENTERS

An additional recommendation of the Carnegie Commission was the establishment of area health education centers. This recommendation was based on the premise that many parts of the country do not provide ready access to the medical centers associated with medical and dentistry schools for treatment or for training of health manpower. In some cases this is true in an urban area where the demand for facilities is so great that existing centers are inadequate to the need. But, mostly, it is true in rural areas where distances alone preclude easy access.

To remedy this defect in the health system, the Carnegie report suggested the establishment of area health education centers, facilities which would be extensions of major medical centers, would have a constant interchange of faculty and students with the affiliated health professions school, and would, in turn, provide needed counseling and training to the surrounding community.

The report suggested, as potential candidates for establishment as area health education centers, community hospitals, specifically calling attention to the possibility of utilizing Veterans' Administration hospitals for these purposes. In fact, the Commission suggested some 17 VA hospitals as good nuclei for these area health education centers. These VA hospitals are at: Montgomery, Ala.; Los Angeles, Calif.; Boise, Idaho; Fort Wayne, Ind.; Topeka, Kans.; Saginaw, Mich.; Biloxi, Miss.; Miles City, Mont.; Grand Island and Lincoln, Nebr.; Fargo, N. Dak.; Altoona and Erie, Pa.; Columbia, S.C.; Amarillo, Tex.; Spokane, Wash.; and Cheyenne, Wyo.

I think it is obvious that the solution of the Nation's health manpower problem will require the combined talents and energies of the private sector and public agencies. It will demand the mobilization of institutions and human resources in widely scattered areas throughout the country.

I agree with the commission that a greater role can be played by the VA hospital system in the overall national health system. The VA system already has achieved recognition as an important contributor to the Nation's health resources.

The Carnegie Commission did express some reservations about the effect on education programs of current Veterans' Administration policies limiting the provision of total health care only to veterans for a service-connected disability or for any disability if they were discharged or released from military service for a disability incurred or aggravated while in military service; and generally limiting care for a non-service-connected disability to those services necessary in preparation for a scheduled hospital admission, or followup care for such an admission, or to a veteran who has a permanent total disability from a service-connected disability.

I also agree with the commission that a greater role should be played by the

Veterans' Administration hospital system in meeting the medical needs of veterans, and, indeed, the chairman of the House Committee on Veterans Affairs (Mr. Teague) and the administration have each authored legislation—H.R. 37 and S. 1924—which will broaden the scope of health care which may be provided veterans. I was delighted to join in introducing (by request) the administration bill—S. 1924—which would permit the provision of medical services for a non-service-connected disability where such care will obviate the need for hospital admission.

I proposed just this concept in my March 4, 1970, speech before the American Legion National Legislative and Rehabilitation Commissions as follows:

"Expanding pre-hospital outpatient care for nonservice-connected conditions to include reasonably necessary care to prevent hospitalization, as well as to prepare for it."

Next week I intend to introduce legislation which would authorize the provision of outpatient care for a non-service-connected disability when such ambulatory care is the most appropriate method of treating that disability. Additionally, I will recommend providing hospital and outpatient care to the wife or children of a veteran having a total and permanent disability which is service-connected and, where such care will not interfere with furnishing services to veterans, providing hospital and outpatient services to widows or children entitled to death compensation or dependency and indemnity compensation under title 38. This same bill will authorize the VA to treat a veteran's family where that is necessary for the veteran's total care and rehabilitation. For example, many psychiatric disabilities can only properly be treated through a family relationship.

With the broadened patient care that will be provided by this proposed legislation, Veterans' Administration facilities will not only provide better care to eligible veterans—that is, by treating "the whole patient" and by treating him as part of a family unit—but education and training programs will provide greater diversity in clinical training and a broader medical experience for the student.

ROLE OF THE VA DEPARTMENT OF MEDICINE AND SURGERY IN TRAINING HEALTH MANPOWER

In the discharge of its major mission, the care and treatment of veteran beneficiaries, the Veterans' Administration produces an important byproduct in trained health manpower. In its huge system of hospitals, clinics, and extended care facilities—by far the largest such system in our Nation under a unified management—the VA has developed programs to assist in the education and training of physicians, dentists, nurses, and more than 60 other categories of health care and administrative support personnel.

Both the quantity and the high quality of these training programs are made possible by cooperation with medical schools, colleges, and universities throughout the country. At the present time, 82 medical schools maintain affiliations with 96 VA hospitals. In addition, the VA is affiliated with 52 dental schools, 287 nursing schools, 75 schools of social work, and 93 graduate departments of psychology. Students are also accepted from schools of physical therapy, occupational therapy, and from universities, colleges, and junior colleges.

Approximately one-half of all physicians entering practice each year receive some of their training in a VA hospital, and large proportions of other health personnel are a product of this system. A total of about 53,000 trainees will be handled through the VA and its affiliates during the current year—fiscal year 1972.

The VA investment in training programs has been highly justified in terms of the consequent improvement in the quality of patient care for the disabled veterans in its facilities. Many VA trainees are thereafter recruited for employment in the agency; and the instructional personnel are among the best in their fields. The existence of educational programs and of university affiliations has proved to be extremely valuable and is today virtually indispensable for the recruitment and retention of full-time health staff in VA hospitals.

CURRENT LIMITATIONS ON VA ROLE

However, despite this substantial contribution and enormous potential, the VA health and hospital system is not now being fully utilized as a resource for the Nation's manpower pool. Nor has its full potential ever been seriously approached.

Undergraduate medical training, including clerkships, and internships, and residency training programs in the VA could readily be expanded to accommodate about 10 percent more—well over 2,000—students in existing facilities. A principal inhibition has been the philosophy—embodied in present section 4101 (b)—that VA training funds should be limited to support of the VA mission. In point of fact, it would be extremely difficult to conduct modern health manpower training within the confines of a single type of health facility.

Full use of the VA system as a health manpower training resource for the Nation is not entirely a matter of direct funding. A major inhibition to full utilization is the lack of a clear legal structure for the present VA operation in the manpower field and the lack of public recognition of this important role. The VA must generally defend its training budgets in reference to agency manpower needs alone or in terms of services actually delivered by students.

A specific commitment to the mission of health manpower development would greatly improve the VA position in reference to affiliations, especially with community colleges and non-Federal hospitals, and would permit expansion even within current levels of spending.

In addition, further expansion of VA medical manpower training programs is inhibited by the limitations of available hospital space and staff time available for teaching.

An untapped potential exists in those hospitals which are not now affiliated with medical schools. These hospitals may be such distances from medical schools that affiliation is prohibited by that factor; or they may be underutilized for teaching by medical schools, because the schools have other adequate clinical facilities available to them.

All but two of the VA hospitals recommended for utilization in area health education centers or university health science centers are hospitals which currently are not now affiliated with medical schools.

To help meet the national health manpower shortage crisis, and to improve the VA system of care for its prime beneficiary, the veteran, I have introduced S. 2219, the proposed Veterans Administration Health Manpower Training Act of 1971. I have been joined in sponsorship of S. 2219 by a most distinguished group of eight other Senators, Mr. BENTSEN, Mr. EAGLETON, Mr. HUGHES, Mr. MANSFIELD, Mr. MONDALE, Mr. NELSON, Mr. RANDOLPH, and Mr. WILLIAMS. I wish to note the generosity of both Senators BENTSEN and MANSFIELD who had introduced an earlier measure—Senate Joint Resolution 76—identical to the more limited House version, House Joint Resolution 464, for joining in the more expansive S. 2219.

I would also like to congratulate my friend and colleague, Congressman OLIN E. TEAGUE, chairman of the Committee on Veterans' Affairs in the House of Representatives, for his success in securing House passage on July 19 of House Joint Resolution 748, which addresses this same problem. I am indebted to Chairman TEAGUE for his leadership in this area and the contribution made by his resolution and its predecessor, House Joint Resolution 464. While our bills differ in several instances, they share a common philosophy and intent. I am confident that this Congress will enact a bill which will enable the Veterans' Administration Department of Medicine and Surgery to expand its role and take on additional responsibilities in furtherance of the Nation's health goals, and at the same time improve the level of quality of care it provides to its prime beneficiary, the veteran.

GENERAL PROVISIONS OF S. 2219

S. 2219 would encourage the greater participation of the VA hospital and medical system in the training of additional health manpower through three major authorities:

First. Provision for expansion of existing Veterans' Administration hospital education and training capacity.

Second. Authority for the implementation of a pilot program to aid in establishing 10 new public nonprofit institutions, which may be medical, other health professions or allied health schools, or area health education centers operated in conjunction with Veterans' Administration medical facilities.

Third. Authority to award grants to medical, other health professions, and allied health schools which are affiliated with VA medical facilities for programs to expand and increase their capacity to train health manpower.

AN EXPANDED MISSION FOR THE VA DEPARTMENT OF MEDICINE AND SURGERY

Mr. President, these new authorities, amending title 38 of the United States Code, are based on a proposed major new expansion of the mission of the VA Department of Medicine and Surgery—D.M. & S.—included in the bill. This expanded mission—to assist in providing an adequate supply of health manpower to the entire Nation as long as that function does not interfere with the Veterans' Administration's primary mission of providing medical care and treatment to veterans—would be added to section 4101(b), in addition to the basic Veterans' Administration Department of Medicine and Surgery mission of caring for sick veterans.

At present, the basic D.M. & S. mission includes training and education of health manpower, but only to the extent that such training would help fulfill the VA major function of providing medical treatment and care to veterans. This inhibits training programs from expanding to their fullest capacity since, in general, further expansion of health manpower training could have been achieved without decreasing the quality or amount of care provided veterans. In fact, it is a well-accepted proposition that where active medical education programs exist, the quality of patient care improves.

LINE BUDGET ITEM FOR HEALTH MANPOWER TRAINING

The bill further encourages the expansion of the VA role in the Nation's health manpower system by requiring a line item appropriation in the VA budget for the education and training of health manpower. This provision should mitigate the difficulties the Department of Medicine and Surgery has faced in the past in having to justify its budget for training in terms of services provided to its hospital patients.

PROXIMITY OF VA HOSPITALS AND MEDICAL SCHOOLS

To foster more affiliations between Veterans' Administration facilities and health education institutions, the bill also includes an amendment to section 5001 (c) of title 38, requiring that any new Veterans' Administration hospital may be constructed only if located near an accredited school of medicine or osteopathy which has agreed to affiliate with the new facility.

Similarly, in the new chapter 82, section 5065, which section 5(a) of the bill would add, relating to pilot programs to assist in the establishment of new medical, other health professions, and allied health schools and area health education centers, such new institutions can be established only if they are located in proximity to and operated in conjunction with Veterans' Administration facilities. This requirement for affiliation is repeated in section 5071 of the new chapter 82 with respect to Veterans' Administration grant assistance to schools of the health professions, and allied health, and area health education centers in that grants may be awarded only to those institutions which are affiliated with a Veterans' Administration medical facility.

SUBCHAPTER 11 EXPANSION OF VETERANS ADMINISTRATION HOSPITAL EDUCATION AND TRAINING CAPACITY

The first major authority granted to the VA in the new chapter 82 which S. 2219 would add—that of expanding existing Veterans' Administration health manpower education and training programs—would provide that up to 30 percent of the amount appropriated for health manpower and training under the new chapter could be utilized for the extension, improvement, remodeling, or repair of Veterans' Administration buildings to make them suitable for manpower education and training programs. This would apply to the provision of equipment, classrooms, lecture facilities, laboratories, and other teaching space as well.

In addition, VA training programs would be supported in the development of improved methods of education and training, including programs to reduce the period of required education and training for health personnel.

This provision is comparable to section 773(e) of the Public Health Service Act, governing the determination of priorities for applications for project grants by health professions schools, which specifies that special consideration should be given to "the extent to which the project may result in curriculum improvement or improved methods of training or will help to reduce the period of required training without adversely affecting the quality thereof.", in addition to considerations of the effect of the proposed project on increased enrollment, and the maintaining of accreditation standing. The new VA provision the bill proposes is similar in philosophy to my amendments, described earlier, to S. 934 and S. 1747 for health professions and nursing education and also to the requirement of innovative reforms required in proposed section 5067(b)(1) in subchapter III and proposed section 5073(b)(5) for subchapter IV programs.

VA TRAINING OF NEW TYPES OF HEALTH MANPOWER

The VA is in a particularly opportune position to develop new methods of training and to experiment with educational requirements. It is a nationwide system, consisting of 165 hospitals—with three more to be activated during fiscal year 1972—in every region of the United States with an outstanding reputation for training, due to its many contributions to the health manpower field. In addition, it has the unique ability to utilize health personnel without regard to the restrictions of State licensing or certification requirements. The Veterans' Administration hospital system is thus in a position to produce new levels and types of personnel; to expand the roles and responsibilities of existing types of personnel; and to put the innovations to a practical test in a clinical setting under the quality supervision of VA and medical school staff. Hopefully, after success is achieved in the VA, the results of these innovations can be provided to the general medical community and can be incorporated into general usage.

For example, the VA provides an almost ideal training ground for the development of new categories of personnel calculated to extend the effectiveness of skilled professionals. It is estimated that existing facilities and VA affiliates could increase their annual production of physicians' assistants by no less than 200 or 300 if additional training funds were made available for this purpose.

Among the most qualified individuals who can benefit from these programs to train new types of health personnel are the returning trained health support personnel of the armed services, such as the Army medic and the Navy corpsman. However, careers in the health fields are by no means limited to those with previous health training. Because of my deep interest in providing career opportunities to veterans and particularly to disabled veterans and veterans of the current conflict in Vietnam, section 5063(c) of the new chapter 82, directs the Administrator to give the highest priority for admission to training programs to qualified individuals who are veterans of the Vietnam era and those who are disabled and that he give priority to qualified veterans in all other cases.

PILOT PROGRAMS FOR THE ESTABLISHMENT OF NEW SCHOOLS OR AREA HEALTH EDUCATION CENTERS

The second new authority included in S. 2219 is subchapter III in the proposed chapter 82: implementing pilot programs for the establishment of new medical, other health professions, allied health, or area health education centers operated in conjunction with existing VA medical facilities. This new subchapter offers a dramatic new means of substantially contributing to the Nation's health manpower needs.

Under this authority, the VA could enter into an agreement with a college or university to establish a medical, other health professions, or allied health professions school or an area health education center, whereby the VA could lease to the college or university land or buildings for a nominal consideration; and make improvements necessary to make them suitable for use in training and education programs. The VA medical facility would provide the clinical setting essential to the training and education of students. In addition, grants could be awarded to these institutions to support the cost of faculty salaries for the first 6 years, with a gradually decreasing level of support, starting at 90 percent and decreasing down to 50 percent. To be eligible for such support, the school would have to show its ability to meet accreditation standards within a reasonable time, and to be able to provide full salary support after the initial 6 years. In addition, such a new school would have to include in its plan such innovations as programs for cooperative interdisciplinary training, emphasizing the team approach in providing health services; and the training for new types of health manpower, such as physicians' or dentists' assistants—assuring the fullest opportunities for career advancement—and programs for recruiting and retaining financially or educationally disadvantaged individuals having potential for training in the health field. These provisions closely resemble the capitation conditions I added to S. 934 and S. 1747.

As I mentioned earlier, there are a number of Veterans' Administration hospitals, presently not affiliated with medical schools, situated in moderate-sized communities some distance from a university medical center, in areas being considered for the establishment of medical schools. Many of these hospitals have sufficient land and buildings to enable them to lease this property to a projected new medical or health professions school. In these locations, the Veterans' Administration hospital could easily provide the primary clinical teaching resources to a school, when supplemented by other local hospital resources in women's and children's diseases. The potential exists in many cases for utilization of the VA hospital in a health professions school, nursing school, allied health school, or an area health education center.

Projections based on the establishment of three medical schools, and one dental school would produce 100 additional graduates by the end of academic year 1976, and each year thereafter—75 physicians and 25 dentists—one projected nursing school would provide 100 new graduates each year after 1977, and some 5,000 individuals would receive training in allied health schools or area health education training centers each year.

SUPPORT OF AFFILIATED HEALTH PROFESSION, ALLIED HEALTH SCHOOL, AND AREA HEALTH EDUCATION CENTERS

The third authority included in S. 2219 is contained in subchapter IV in the new chapter 82: direct financial support to schools affiliated with VA facilities to provide encouragement to such schools to expand and improve their capacities to train health manpower. The support would be provided only if it would result in a substantial increase in the number of students trained at the school—if such an expansion would not endanger its accreditation standing—or compromise the quality of education, and the school plans to include significant programs for the training of new types of health personnel, including physicians', dentists', and other health professions' assistants, and nurse practitioners.

One of the major benefits of this provision will be its impact on emerging medical schools and other health professions schools affiliated with VA facilities. Through grant support and the benefit of VA clinical settings they should produce significantly more and new types of graduates at a faster pace.

APPROPRIATIONS AUTHORIZATION

To carry out the purposes of the new chapter 82 to be added by S. 2219, an appropriation of $125 million for each of fiscal years 1972 through 1977 is authorized. The allocation of the amount appropriated among the three programs of the new chapter 82 of part VI of title 38, U.S. Code, is left to the discretion of the Administrator of Veterans Affairs, with the exception that no more than 30 percent may be utilized for programs under the new subchapter II—Expansion of Veterans' Administration Hospital Education and Training Capacity.

EMPHASIS ON CURRICULUM IMPROVEMENT AND ENROLLMENT EXPANSION

I would like to call attention to the major emphasis placed in S. 2219 on programs which attack the critical health manpower shortage and at the same time provide incentives for improvement and innovation in curricula.

In each of the three major subchapters of subchapter 82, assistance is conditioned on the inclusion in a training program—whether it be in a Veterans' Administration hospital, in a pilot program institution, or in an affiliated health education school or area health education center—of certain objectives. These objectives reflect the capitation condition programs I amended into S. 934 and S. 1747. They are to:

Reduce the period of required education and training for health personnel without adversely affecting the quality of such education or training;

Develop or initiate improved methods of education and training;

Attract qualified veterans to the health professions and para-professions;

Develop cooperative interdisciplinary training among health professions and allied health schools with emphasis on the use of the team approach in providing health services;

Expand and improve education and training opportunities for allied health and other health personnel;

Develop institutions that can become viable and self-supporting;

Train for new roles, types, or levels of health manpower, including physicians' assistants, dentists' assistants, nurse practitioners, providing the fullest opportunities for career advancement and mobility.

Recruit, enroll and retain qualified individuals, who, due to socio-economic factors, are financially or educationally disadvantaged;

Maintain accreditation standards;

Increase numbers of students trained.

POTENTIAL APPLICATION OF PROVISIONS

The initial reaction from the medical community to provisions included in S. 2219 has been enthusiastic. The potential applications of its provisions are numerous.

Of the 114 schools currently listed by the AMA as approved or in development, only 24 are not now or currently planning to be affiliated with the VA. At the same time, the Veterans' Administration has made it a policy that no future VA health facilities will be established except in locales adjacent to health professions education institutions.

In my own State of California alone, the Loma Linda University School of Medicine has requested that a Veterans' Administration hospital be constructed near it; schools already affiliated with VA hospitals have sought further relationships—the University of Southern California, Stanford University School of Medicine; and the University of California Medical Schools at Davis, Los Angeles, and San Francisco. Several have indicated a willingness to consider providing land for the construction of a new Veterans' hospital near the medical school. Also, the Veterans' Adminstration Hospital in San Diego, Calif., now under construction, is being built on land donated by the University of California at San Diego School of Medicine.

As I mentioned earlier, the Carnegie Commission has suggested 20 likely VA hospitals which could be associated with university health science centers or serve as the nuclei for area health education centers. In California, these include the VA facilities in Fresno and in Los Angeles.

In addition, I have received letters from leaders in the health education field in California suggesting affiliations between the VA hospital in San Francisco—Fort Miley—and the City College of San Francisco nursing school; the VA facility in San Diego and allied health professions training programs; and the University of California at Los Angeles School of Nursing and the Brentwood Veterans' Administration Hospital, in the training of the Geriatric Nurse Practitioner.

Mr. President, I request unanimous consent that there be set forth at this point in the RECORD statements I have received from Dr. Rheba de Tornyay, Dean of the School of Nursing at the University of California, Los Angeles and from Dr. Clifford Grobstein, Dean of the School of Medicine, University of California, San Diego regarding the applicability of S. 2219 to potential programs at those schools.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

REACTION TO THE "VETERANS ADMINISTRATION HEALTH MANPOWER TRAINING ACT"

(Prepared by Rheba de Tornyay, R.N., Ed. D. Dean designate, UCLA School of Nursing)

The "Veterans Administration Health Manpower Training Act of 1971" will provide much needed assistance to schools of nursing both to increase enrollment in existing training programs and to provide additional facilities for preparing nurses for increasing responsibilities in the care of people.

The need for increasing the supply of nurses has been well documented. Community college nursing programs throughout California are providing first level registered nurses economically in terms of time and tax-based support. These nurses, prepared in a two year program, have demonstrated their ability to perform skillfully standardized nursing measures as well as provide the environment and interaction necessary to promote the health objective of the patient. The community need for these nurses, and the applicants for enrollment to the community college nursing program, continues to be greater than the schools can accommodate with current budget and facilities. An example can be cited from City College of San Francisco. The chairman of the nursing program Miss Ginello Griffin, indicates that this program should double its enrollment from the current 100 students to 200 students based on community demand. Chief deterrents to such expansion are budgeted nursing faculty positions, and lack of adequate clinical facilities in the San Francisco Bay Area. A Veterans Hospital is located in San Francisco with patients having health problems requiring traditional nursing care. This school would be assisted to increase its enrollment if additional nursing faculty and classroom space as well as clinical resources were available. The proposed "Veterans Administration Health Manpower Training Act of 1971" would provide necessary assistance to this particular school of nursing to increase its enrollment appreciably. This school of nursing is particularly sensitive to the needs for upward mobility for vocational nurses seeking education to qualify to become registered nurses. A large number of these vocational nurses are members of minority ethnic groups, and according to the chairman of the nursing program the three major deterrents in accepting many more qualified members of the nursing team are budgeted faculty positions, clinical facilities, and classroom space. This proposed legislation would provide relief in all three areas.

Baccalaureate nursing education is currently being revised to include the skills of diagnostic health screening, and the management of specified health problems. Through collaborative efforts between medicine and nursing, nurses with baccalaureate and higher degrees will be assuming responsibilities that have traditionally been the responsibility of the physician. Nursing is uniquely suited to provide assistance to patients in the psycho-social realm of human needs, such as counseling and teaching. There is considerable discussion at the present time about the nurse's role as a "primary care agent" for patients whose major problems are ones of adjustment to illness and infirmity, as well as assistance in coping with their disabilities. The management of stabilized chronic long-term illness will undoubtedly become a nursing responsibility in the future.

The objective of helping each person to live his life in comfort and dignity is a central nursing goal. All older Americans, and most certainly a citizen who has served his country in its time of need, deserves personalized and humane care. An area of health care as yet undeveloped is the Geriatric Nurse Practitioner. These nurses would be prepared through carefully supervised clinical experiences with concurrent theoretical courses to work independently with older patients presenting chronic physical and emotional problems. This preparation would most likely occur in the senior year of the baccalaureate nursing program to provide a broad-based background in the pathophysiological processes as well as the psychosocial needs of patients. The nurse would assume responsibility for patient health screening, counseling, teaching, and continuous evaluation and health management. Through team efforts, the nurse would refer those patient problems that are primarily medical in nature to the physician, and those social problems that require complex assistance to the social worker. Other members of the health team would assist depending on the patient's needs, but the nurse would assume responsibility for referral and coordination of patient activities. To date, such a program has not been developed as an integral part of a baccalaureate nursing program.

The University of California, Los Angeles, School of Nursing is well able to assume responsibility for the development of a geriatric nurse practitioner program. Located in a Center for the Health Sciences with a Medical School, this Center is in close proximity to the Brentwood Veterans Hospital complex. The School of Nursing does utilize the facilities of the Wadsworth and Brentwood hospitals for clinical nursing experiences, but to date has not included the extended care facilities of the Veterans' Hospital. If additional faculty could be added to the school of nursing faculty, a project for preparing Geriatric Nurse Practitioners could be undertaken to produce nurses prepared for primary roles in caring for patients with chronic problems, in conjunction with the Veterans' Hospital. Research is badly needed in long term illness, for example, on the effects of such interventions as stimulation and irritation to prevent sensory deprivation and its effect on the central nervous system. The utilization of the extended care facility of this Veterans' Hospital would provide much needed research facilities for the graduate program in nursing at UCLA. The funds provided by this proposed legislation could assist in providing both classroom space and laboratory space for such research efforts.

The partnership of a school of nursing financed through local taxes, such as a community college, or through State support as the University of California and the Federal Government through the use of Veteran's hospitals will benefit all—patients, students, and the communities involved.

University of California, San Diego,
LaJolla, Calif., June 7, 1971.

Hon. Alan Cranston,
U.S. Senate,
Washington, D.C.

Dear Senator Cranston: I understand that you have under consideration legislation to promote health professional educational efforts by the VA. I believe that such legislation, appropriately drafted, would make a substantial contribution to the mission of the VA as well as to health manpower needs. I would emphasize that to accomplish this new legislation must expand and strengthen existing VA-medical school relationships and recognize that the academic rather than the hospital side of the relationship should have the initiative in educational matters.

Here at San Diego, we have a developing School of Medicine alongside of a shortly-to-be-opened VA Hospital. Additional resources supplied either to the School or the Hospital will substantially accelerate our program for health manpower production. For example, we will take our fourth class of approximately 50 entering M.D.-students this coming fall. Whether we can enroll our projected full class of 96 students in the fall of 1972 depends on additional resources for faculty and patient care. Funding of our Clinical Science Building, as you know has been delayed and we will not have an on-campus hospital of our own for at least five years. Additional research and teaching space in the VA Hospital, plus broadened utilization of patient care facilities there, would essentially guarantee our efforts to achieve our initial objective despite other delays. Moreover, it would enable us to begin to consider moving beyond the original program when earlier projected facilities become available.

We have considerable interest, also, in promoting allied health professional training at the VA. Along with other institutions in the area, we have established a Coordinating Council for Education in Health Sciences in San Diego and Imperial Counties. Suitably augmented, the new VA Hospital can play an important role in establishing a Health Education Center for the region.

Accordingly, I endorse your efforts to secure new enabling legislation. I hope that the provisions will encourage flow of support to both the Medical School and the VA Hospital so that each will be motivated toward a mutual approach, rather than an arrangement dominated by either party.

With many thanks for your continued interest in this vital area.

Sincerely yours,

Clifford Grobstein,
Vice Chancellor for Health Sciences and Dean of the School of Medicine.

Mr. Cranston. Mr. President, I also request unanimous consent to set forth next in the Record a series of tables indicating projections for the training and education of individuals and for the establishment of medical, dental, and nursing schools and area health education centers under the provisions of S. 2219.

There being no objection, the tables were ordered to be printed in the Record, as follows:

POSSIBLE USE OF $125,000,000 UNDER NEW CH. 82 IN S. 2219 PER YEAR OVER 6 YEARS FOR VARIOUS PURPOSES RELATED TO ACTIONS BY VA TO EXPAND THE NATION'S HEALTH MANPOWER POOL

[In thousands of dollars]

Year	Sec. 5061			Sec. 5067—New schools			Sec. 5073—expand present affiliated schools	Administration	Total by year
	Alter VA facilities	Special allocation to VAH	Total	Construction	Salaries	Total			
1	15	22.5	37.5	20	3.2	23.2	61.8	2.5	125
2	23	14.5	37.5	20	12.3	32.3	52.7	2.5	125
3	23	14.5	37.5	20	21.8	41.8	43.2	2.5	125
4	23	14.5	37.5	20	20.0	40.0	45.0	2.5	125
5	23	14.5	37.5	10	24.8	34.8	50.2	2.5	125
6	23	14.5	37.5	10	29.9	39.9	45.1	2.5	125
Total	130	95.0	225.0	100	112.0	212.0	298.0	15.0	750

ALLOCATION OF CONSTRUCTION COSTS FOR NEW SCHOOLS UNDER SUBCHAPTER III OF CHAPTER 82

[In millions of dollars]

	1 school	Total
4 medical and 1 dental school	15.38	76.90
1 nursing school	7.69	7.69
4 others	3.84	15.41
Total		100.0

SCHEDULE FOR OPENING OF NEW SCHOOLS UNDER SUBCHAPTER III OF CHAPTER 82

Program year	Number of schools starting [1]				
	Medical	Dental	Nursing	Other	Total
1	3	1	1	2	7
2	1			2	3
Total	4	1	1	4	10

[1] *Students would be 1st accepted in the year after start.*

PROJECTED ENROLLMENT FOR NEW SCHOOLS UNDER SUBCHAPTER III OF CHAPTER 82

A. EACH MEDICAL SCHOOL, AND THE DENTAL SCHOOL, WILL HAVE 50-STUDENT CLASSES—EXCEPT FOR THE FIRST ENTERING CLASS WHICH WILL BE 25

Program year	Enrollment			Total	Graduates by end of indicated year
	3 medical schools and 1 dental school accepting students in program year 2		1 medical school accepting students in program year 3		
	1 school	4 schools			
1973	25	100		100	
1974	75	300	25	325	
1975	125	500	75	575	
1976	175	700	125	825	100
1977	200	800	175	975	200

B. THE NURSING SCHOOL (4-YEAR) WOULD ACCEPT AN INITIAL ENTERING CLASS OF 50 STUDENTS IN THE 2D PROGRAM YEAR, AND 100 EACH YEAR THEREAFTER. CONSEQUENTLY ITS ENROLLMENT AND GRADUATES WOULD BE AS FOLLOWS

Program year	Enrollment	Graduates
1973	50	
1974	150	
1975	250	
1976	350	50
1977	400	100

Note: C. The "other" schools are expected to have an enrollment of 5,000 different students, in classes of variable length during the 6th program year.

USE OF FUNDS FOR SUBCHAPTER IV OF CHAPTER 82

Given the circumstances of the economy and the manpower market in 1971, it is not possible to address the nation's health manpower needs in terms of numbers in specific fields or professional disciplines. Jobs in the allied health fields, particularly at the technical level do not warrant the expense, to the employee or the employer, of relocation. Therefore, priorities must be based on the needs for health services as they are faced by individual communities or health service areas, concentrating attention not only on basic training but on distribution, utilization and retention of personnel.

Priorities for allocation of funds administered under Subchapter III will be based on the relevance of the proposed programs to the demonstrated needs of the community served by the applicant, i.e., training programs which will produce manpower, with the appropriate capabilities and skills and in reasonable numbers, to provide the kinds of services most seriously needed by the community (including the VA system in that community).

1. Physician
2. Nurse
3. Dentist
4. Laboratory Service personnel
5. Radiology Service personnel
6. Dental Auxiliary personnel
7. Physicians' Assistants
8. PM&R Therapy personnel (Physical Medicine and Rehabilitation)
9. Clinical Psychologist
10. Social Worker
11. Speech pathologist and Audiologist
12. Inhalation Therapist
13. Nurse Anesthetist
14. Medical Record Library personnel
15. Dietetics personnel

Mr. CRANSTON. Finally, Mr. President, I ask unanimous consent that there be printed last in the RECORD a section-by-section analysis of S. 2219, followed by the full text of the bill with typographical errors corrected.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

SECTION-BY-SECTION ANALYSIS OF S. 2219, PROPOSED "VA HEALTH MANPOWER TRAINING ACT OF 1971"

Section 1. Establishes the title of the proposed Act as the "Veterans Administration Health Manpower Training Act of 1971".

Section 2. Sets forth eight findings and declarations by the Congress with respect to the nation's shortage of qualified health manpower; the great needs for expansion of training and education of health manpower; the unique and substantial untapped capacity of the Veterans' Administration (with its existing affiliations with 81 (this number has increased to 82 since introduction of S. 2219) medical schools, 287 nursing schools and 400 institutions of higher learning which educate and train health manpower) to assist in the expansion and improvement of existing and the establishment of new affiliated medical, other health professions and allied health schools and area health education centers as well as generally to assist in the expansion and improvement of education and training opportunities for all health personnel; and the essentiality of increased training of health manpower if the nation is to provide the best possible medical care for its veterans. The specific clauses in the section are self-explanatory.

Section 3. Revises subsection (b) of section 4101 of title 38, regarding functions of the VA's Department of Medicine and Surgery (DM&S), by adding to the basic VA mission (providing complete medical and hospital services for veterans) the function of assisting in providing an adequate supply of health manpower to the entire Nation as long as that function does not interfere with the primary mission. Subsection (b) presently *limits* education and training activities to those "in order to more effectively carry out" the basic DM&S mission. Under the revised subsection, the Administrator, in order to assist the Nation to meet its needs for more health manpower, is directed to carry out this program of education and training of health manpower in cooperation with health professions and allied health schools, other institutions of higher learning, academic health centers, and area health education centers.

The revised subsection also would add a new second sentence requiring that the President's annual budget request contain a separate line item for health manpower education and training.

The new subsection (b) resembles the VA-proposed revision (included in section 201 of the administration bill—S. 1924) and establishes the basic framework for the chapter 82 to be added to part VI of title 38 by section 5 of the bill (S. 2219).

Section 4. Adds at the end of subsection 5001(c) of title 38, regarding the location of VA hospital and domiciliary facilities, a requirement—reflecting present VA policy—that a new VA hospital shall be constructed only in close proximity to an accredited medical or osteopathic school which is affiliated or has agreed to affiliate with the VA hospital in question and that such construction shall include such classrooms, lecture facilities, laboratories, and other teaching space, facilities, aids and beds necessary to carry out health manpower training in accordance with the purpose of the new chapter 82 to be added by section 5 of the bill. Similar language is included in the proposed subchapter II (section 5064) of the new chapter, regarding improvements to existing VA health facilities, for the same health manpower education and purpose, as in this amendment to section 5001(c) in section 4 of the bill.

Section 5. Subsection (a). Adds to Part VI of title 38, regarding acquisition and disposition of VA hospital and domiciliary property, a new chapter 82, entitled "Utilization of Veterans' Administration Hospitals to Improve and Expand Education and Training of Health Manpower".

Subchapter I of the new chapter 82. Sets forth basic requirements for coordination with other Federal programs and promulgation of regulations, authorizes appropriations to carry out the new chapter, and establishes certain limitations on expenditure of funds.

New Section 5061 adds the requirement that the Administrator and the Secretary of Health, Education, and Welfare shall, to the maximum extent practicable, coordinate programs carried out under the new chapter 82, of title 38, and programs carried out under Public Health Service Act section 309 (Project Grants for Graduate Training in Public Health), title VII, (Health Research and Teaching Facilities and Training of Professional Health Personnel, including Training in the Allied Health Professions) title VIII (Nurse Training) and title IX (Education, Research, Training, and Demonstrations in the Fields of Heart Disease, Cancer, Stroke, Kidney Disease, and Other Related Diseases).

New Section 5062 authorizes appropriations of $125,000,000 each for fiscal years 1972 through 1977, and stipulates that any funds appropriated pursuant to this section shall remain available until expended. This section further stipulates that no more than two percent of the funds appropriated pursuant to section 5062 for any fiscal year may be used for administrative expenses in carrying out the provisions of the new chapter 82.

New Section 5063. Subsection (a) prohibits the Administrator from entering into agreements under provisions of the new chapter 82 with respect to Subchapter III pilot programs (for assistance in the establishment of new, public nonprofit medical, other health professions, and allied health schools and area health education centers) after the close of the sixth calendar year after the calendar year in which chapter 82 would take effect, and sets the same prohibition with respect to Subchapter IV grants (for assistance to affiliated medical, other health professions, and allied health schools, other health manpower training institutions, and area health education centers).

Subsection (b) authorizes the Administrator to establish the Advisory Subcommittee on Programs for Assistance for Health Manpower Education and Training of the Special Medical Advisory Group established pursuant to section 4112 of Title 38, and further prohibits the Administrator from entering into any agreements or making any grants under these same programs without prior consultation with such Advisory Subcommittee. This subsection further provides that the Assistant Chief Medical Director for Research and Education in Medicine shall be an ex officio member of the new Subcommittee.

Subsection (c) directs the Administrator to ensure that qualified persons who are veterans shall be given priority for admission to health manpower education and training programs assisted under the new chapter 82 or any provision of title 38, and that among these qualified veterans, highest priority be given to those who served during the Vietnam era and those who are entitled to Veterans' Administration disability compensation, or whose discharge or release was due to a disability incurred or aggravated in line of duty.

Subsection (d) directs the Administrator, after consultation with the Advisory Subcommittee established pursuant to new section 5063(b), to prescribe regulations covering terms and conditions for entering into agreements under subchapter III and making grants under subchapter IV of the new chapter 82.

Subchapter II of the new chapter 82. Sets forth new ways for the Administrator to expand the Veterans' Administration Hospital in-house education and training health manpower capacity.

New Section 5064 provides that up to 30 percent of the sums appropriated pursuant to the authorization in the new section 5062 may be spent to extend, expand, alter, improve, remodel or repair VA buildings and structures (including equipment and, where necessary, the addition of teaching space, aids, and beds) to the extent necessary to make them suitable for use for health manpower education and training to carry out the expanded mission of the Department of

Medicine and Surgery as it would be newly defined in the amended section 4101 (b) of title 38 (to assist in providing an adequate supply of health manpower to the Nation, as long as that does not interfere with the primary VA mission of providing complete medical and hospital services for veterans) and that these funds may also be spent for the development of improved methods of education and training which may reduce the period of required education and training for health personnel without adversely affecting the quality of such education or training.

Subchapter III of the new chapter 82. Authorizes the implementation of a pilot program for assistance in the establishment of new public nonprofit medical, health professions, and allied health schools and area health education centers, if located in proximity to and operated in conjunction with VA medical facilities.

New Section 5065 sets forth the purposes of the subchapter.

New Section 5066 defines the term "area health education center," "health professions school" and "state."

New Section 5067. Subsection (a) describes the assistance which may be provided to eligible institutions as follows:

(1) Leasing to the college or university of land, buildings and other structures (including equipment therein) under the control of the Veterans' Administration, as may be necessary for the establishment and operation of a school or center as defined in new section 5066. Adopting the general proposal in section 301 of the administration sponsored bill, S. 1924, any lease made pursuant to subchapter II of new chapter 82 would be authorized to be made without regard to the provisions of section 5 of title 41. United States Code, which requires advertising where the lease exceeds $500. Since any lease under this section would not be for commercial purposes, but only for health, or educational purposes, advertising in these cases serves no useful purpose but does involve time and expense that is considered unnecessary.

In addition, any lease under this subchapter would be exempt from the provisions of section 303b of title 40, which bars lease provisions calling for alteration, repair, or improvement of such leased property as part of the consideration for the rental to be paid.

Under the proposed change, the lessee would be permitted to maintain, protect, or restore property where such property is leased to public or nonprofit organizations. In negotiating the rental value, practice is to set a rate that will serve to recapture the value of all services provided by the Government. In some instances if the lessee were required to provide for maintenance and protection of the property leased, the Veterans' Administration could be relieved of certain expenses for materials and personnel.

(2) Extension, remodeling, or repair of building and structures (including the provision of initial equipment, or the replacement of obsolete or worn out equipment) and, where necessary, the addition of hospital teaching beds, to the extent necessary to make the VA hospital in question suitable for use as a health professions school or area health education center facility.

(3) Payment of grants to support the costs of faculty salaries during the first six years of the school or center's operation, such support to represent not more than 90 percent of the cost of faculty salaries during the first three years of operation and no more than 50 percent during the second three years of operation.

Subsection (b). Paragraph (1) sets forth requirements that must be met prior to the Administrator entering into agreements pursuant to new section 5067(a) as follows:

A. The college or university must submit a plan whereby it agrees to provide during the term of the agreement its share of the financial support for the proposed school or center, including full financial support for all programs essential to assure that the school will meet the accreditation standards of appropriate accreditation bodies approved for such purpose by the Commissioner of Education of the Department of Health, Education, and Welfare.

B. The overall plans for the school or center must meet such professional and other standards as the Administrator deems appropriate, in consultation with the Secretary of Health, Education and Welfare; and must include significant programs for cooperative interdisciplinary training among health professions and allied health schools with emphasis on the use of the team approach in providing health services, training for new roles, types or levels of health manpower, including training of physicians', dentists' or other health professions' assistants and/or nurse practitioners, providing for career mobility, or programs for recruiting, enrolling, and retaining qualified individuals who due to socioeconomic factors are financially or educationally disadvantaged.

C. The school must maintain mutually beneficial arrangements with the Veterans' Administration medical facility with which it is associated.

4. The school must show that there is reasonable assurance that with the aid of an agreement under new section 5067(a) it would meet the accreditation standards of appropriate bodies.

Subsection (b). Paragraph (2) directs that any agreement entered into pursuant to subchapter III shall contain such terms and conditions as the Administrator deems necessary and appropriate to protect the interest of the United States.

Subsection (c) limits the Administration to providing assistance in the establishment of a total number of no more than ten new health institutions, which may be public nonprofit health professions and allied health schools or area health education centers, and directs that schools and centers established with assistance under subchapter III shall be geographically dispersed throughout the United States.

Subchapter IV of the new chapter 82. Provides for assistance to affiliated medical, other health professions, and allied health schools and other health manpower training institutions, and area health education centers.

New section 5071 declares the purpose of Subchapter IV to make grants to health manpower training institutions affiliated with the V.A. in order to assist such institutions to expand and improve their capacities to train health manpower.

New section 5072 defines the term "eligible institution" as being a nonprofit public or private health professions school of the type defined in section 5066, area health education center of the type defined in section 5066, or institution for the training or education of allied health or other health personnel, which maintains an affiliation with the Veterans Administration. Unlike Subchapter III, assistance under Subchapter IV is available for nonprofit private institutions, whereas Subchapter III includes only public institutions.

New Section 5073. Subsection (a) sets forth the purposes for which grants to eligible institutions may be awarded. These purposes are to carry out projects and programs for the expansion and improvement of the institution's capacity to train health manpower. Grants which provide for the construction of facilities may include only the extension, expansion, alteration, improvement, remodeling or repair of existing structures (including provision of initial equipment and replacement of obsolete or wornout equipment).

New Section 5073. Subsection (b) authorizes approval of applications for a grant under section 5073 only if:

> (1) the grant will be for a project or program which will make a significant contribution to improving the education (including continuing education) or training program of the eligible institution and will also result in a substantial increase in the number of students trained at the institution;
>
> (2) there is assurance that the increase in the number of students will not threaten any existing accreditation or compromise the quality of training at the institution;
>
> (3) the application provides for proper fiscal control and accounting procedures;
>
> (4) the application provides for making appropriate reports and keeping such records as the Administrator may require; and
>
> (5) the application sets forth significant programs for the education and training of physicians, dentists, or other health professions' assistants, or nurse practitioners, or other new types of health personnel, providing the fullest opportunities for career advancement and mobility.

New Section 5074 provides for the manner in which payment may be made pursuant to grants under subchapter IV.

* * * * * * *

Section 5. Subsection (b) of S. 2219. Makes conforming changes in the table of parts and chapters at the beginning of title 38 and the table of chapters at the beginning of part VI of title 38.

Section 6. Provides that during the two years immediately following enactment of this Act, no part of any real property under the jurisdiction of the Administrator of Veterans' Affairs on the date of enactment of this Act shall be determined to be excess to the needs of the Veterans' Administration or transferred or otherwise disposed of.

[The text of S. 2219 with typographical errors corrected, referred to in Senator Cranston's floor statement, appears at page 6.]

[No. 25]

COMMITTEE ON VETERANS' AFFAIRS, UNITED STATES SENATE

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., August 4, 1971.

Hon. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This will respond to your request for a report by the Veterans' Administration on S. 2219, 92d Congress, the "Veterans' Administration Health Manpower Training Act of 1971."

The declared congressional purpose stated in the bill is the use of the medical program of the Veterans' Administration's Department of Medicine and Surgery to assist in the establishment of new and the expansion and improvement of existing affiliated medical, other health professions and allied health schools and area health education centers, in order to train an adequate number of physicians, health professionals, allied health personnel, and other health personnel, to discharge the responsibility of the Congress to provide the best possible medical care for the Nation's veterans.

Briefly, the purposes of the bill would be accomplished by—

(1) Expanding the current training mission of the Department of Medicine and Surgery to assist in providing an adequate supply of health manpower to the Nation;

(2) Providing that any new hospital shall be constructed in close proximity to a medical school which agrees to affiliate;

(3) Expanding Veterans' Administration hospital education and training capacity;

(4) Assisting in the establishment of new medical, health professions, and allied health schools and area health education centers; and

(5) Providing assistance to affiliated medical health professions, and allied health schools and other health manpower training institutions, and area health education centers.

There is enclosed a more detailed section-by-section analysis of the bill.

We favor the proposed expansion of the authority of the Administrator of Veterans' Affairs to develop and carry out a program of education and training of health manpower beyond the direct needs of the Department of Medicine and Surgery, as contained in section 3 of the bill. This provision is similar to one contained in a draft proposal which I submitted to the Congress on February 10, 1971, which was introduced as S. 1924, and is currently pending before your committee. However, we do not favor that portion of section 3 which requires that there be included in the budget required to be submitted to Congress a line item showing the estimated expenditure by the

Veterans' Administration during each fiscal year for the education and training of health manpower.

Pursuant to an agreement between the Veterans' Administration and the Office of Management and Budget, the activities listed in the program and financing schedule for the medical care appropriation have been revised to provide for the separate identification of education and training costs, effective with the fiscal year 1972 budget. We feel that this action meets the intent of the proposed legislation to make information regarding the Agency's estimated expenditures for training and education of health service personnel readily identifiable and available to the Congress. We do not favor the inclusion of a separate line item in our budget and oppose any legislative limitation on the amount of appropriated funds available for education and training because of the loss of flexibility needed in the medical program.

While we recognize and have repeatedly commented on the desirability of locating our hospitals in close proximity to medical schools, there are other factors which we feel are important to consider. They include veteran-population concentration, demand and ability to recruit professional staff. Although one or more of these factors may be enhanced by close location to a medical school, we would prefer not to be directed to locate any new hospital near a medical school as is done in section 4 of the bill. We believe that the best policy in this regard is to continue current authority in the Administrator, subject to the approval of the President, as vested in section 5001(c) of title 38, United States Code, to decide where VA hospitals should be located.

Subchapter I of the proposed new chapter 82 authorizes an appropriation of $125 million for the fiscal year ending June 30, 1972, and a like sum for each of the 5 succeeding fiscal years, with not more than 2 percent to be used for administrative expenses. Subchapter II provides that not to exceed 30 percent of those funds may be expended for necessary alteration, remodeling or expansion of VA facilities and for other special allocations (including trainee stipends and instructor salaries).

Subchapter III establishes a pilot program under which the Administrator may provide assistance in the establishment of new public nonprofit health professions and allied health schools, and area health education centers if such schools and centers are located in proximity to, and operated in conjunction with, Veterans' Administration medical facilities. The pilot program would permit the Administrator to enter into agreements with colleges or universities for the establishment of more than 10 such new schools, located in geographically dispsersed areas of the United States.

Subchapter IV authorizes the Administrator to carry out a program of grants for eligible health manpower training institutions and area health education centers which maintain affiliations with the Veterans' Administration in order to assist them in expanding and improving their capacities to train health manpower.

For over 25 years, hospitals of the Veterans' Administration have been offering hospital-based educational experience in collaboration with most of the Nation's medical schools. Veterans' Administration hospitals are currently affiliated with 81 medical schools, 51 dental schools, 287 nursing schools, 274 universities and colleges and 81 community and junior colleges. During the current fiscal year, more than 50,000 students will participate in more than 60 categories of training in Veterans' Administration institutions. Thus, the Veterans' Administration's contribution in the field of health education has been substantial.

The success and productivity of this partnership between an agency of the Government and the non-Federal system of higher education in the interest of the entire health care system has won the confidence and support of all.

However, we do not feel that the placing of grant authority in the Veterans' Administration for the purposes set forth in S. 2219 is the proper approach for expanding medical education facilities in the context of the broad national programs for these objectives. The subject bill would duplicate and overlap current authorities under the Health Professions Educational Assistance provisions of titles VII and VIII of the Public Health Service Act to assist in the establishment of new schools of medicine, the expansion of existing schools, the provision of operating support under both formula and special project grants, and the training of health service personnel.

The President has emphasized the need for consolidation and coordination of granting mechanisms throughout the Federal Government, stating in his "Health Message" to the Congress on February 18, 1971:

* * * * * * *

> "In addition, I believe that Federal support dollars for the construction of medical education facilities can be used more effectively. I recommend that the five current programs in this area be consolidated into a single, more flexible grant authority and that a new program of guaranteed loans and other financial aids be made available to generate over $500 million in private construction loans in the coming fiscal year—five times the level of our current construction grant program.
>
> "Altogether, these efforts to encourage and facilitate the expansion of our medical schools should produce a 50-percent increase in medical school graduates by 1975. We must set that as our goal and we must see that it is accomplished.
>
> * * * * * * *
>
> "I recommend that our allied health personnel training programs be expanded by 50 percent over 1971 levels, to $29 million, and that $15 million of this amount be devoted to training physicians' assistants. We will also encourage medical schools to train future doctors in the proper use of such assistants and we will take the steps I described earlier to eliminate barriers to their use in the laws of certain States."

* * * * * * *

Legislation which would accomplish many of the President's recommendations has passed both the House and the Senate in differing forms and is now being considered by a conference committee (H.R. 8629 and H.R. 8630).

S. 2219, contrary to the foregoing objective, would establish the Veterans' Administration as a separate agency for supporting the construction and operation of medical and health schools when we already have a bureau for this purpose at the National Institutes of Health under the Department of Health, Education, and Welfare. In the face of a Presidential proposal to consolidate existing grant programs, it would have a contrary result by contributing to their further fragmentation.

We are of the view that the administration of any grant program for these stated purposes should be maintained in the Department of Health, Education, and Welfare.

Section 6 of the bill provides that for a 2-year period immediately following the date of enactment, no part of any real property, under the jurisdiction of the Administrator of Veterans' Affairs, on January 1, 1971, shall be determined to be excess of the needs of the Veterans' Administration, or transferred, or otherwise disposed of, pursuant to any provision of the Federal Property and Administrative Services Act of 1949.

Present Veterans' Administration policy in the review of our real property holdings to determine whether such holdings are excess to our needs, and in our master planning for optimum land use in accordance with long-range plans, include in the criteria for consideration, possible use for affiliated medical schools or health care training facilities, as well as Veterans' Administration physical facilities, roads and parking recreation areas, overall esthetics, buffer zones, easement granted to public utility companies, State, or local governments, topography, and cemeteries, to assure that land which is essential to Veterans' Administration activities and responsibilities is not mistakenly declared excess. We feel that this policy assures the maintenance of all Veterans' Administration interests in real property necessary to our long-range planning, and that the provisions of section 6 of the bill impose an undue and unnecessary limitation on the authority of the executive branch of the Government to dispose of real property excess to the present and future needs of the Federal Government.

Accordingly, I strongly oppose enactment of S. 2219. I believe that legislation more closely implementing the President's program is the proper approach to the expansion of national medical manpower resources.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

DONALD E. JOHNSON,
Administrator.

Enclosures.

SECTION-BY-SECTION ANALYSIS OF S. 2219, 92D CONGRESS

SECTION 1

Section 1 provides that the act may be cited as the "Veterans' Administration Health Manpower Training Act of 1971."

SECTION 2

Section 2 sets forth the findings and declarations of Congress. This section notes that: (1) there is a shortage of health manpower in the United States; (2) lists certain health professionals shortages; (3) the Veterans' Administration operates the largest medical care system in the United States; (4) the Department of Medicine and Surgery of the Veterans' Administration maintains an active and close affiliation with numerous schools of higher learning; (5) there is a need to expand the health manpower pool of the Nation; (6) education training opportunities and the capacities of medical and health profession schools affiliated with the Veterans' Administration must be expanded and improved; (7) the Veterans' Administration's Department of Medicine and Surgery is qualified to assist in the expansion and improvement of existing affiliated medical, health professions, and allied health schools and area health education centers; in the expansion and improvement of education and training opportunities for allied health and other health personnel and in the establishment of new public nonprofit medical, health professions and allied health schools and area health education centers; and (8) adequate number of health personnel must be trained in order to provide the best possible medical care for the Nation's veterans.

SECTION 3

Section 3 would amend section 4104 of title 38, United States Code, by deleting subsection (b) and inserting in lieu thereof a new subsection (b) which would provide that in order to carry out more effectively the primary function of the Department of Medicine and Surgery to provide a complete medical and hospital service for the medical care and treatment of veterans and to assist in providing an adequate supply of health manpower to the Nation, the Administrator shall, to the extent feasible without interfering with the medical care and treatment of veterans, develop and carry out a program of education and training of such health manpower, acting in cooperation with such schools of medicine, osteopathy, dentistry, nursing, pharmacy, optometry, podiatry, public health or allied health profession; other institutions of higher learning; medical centers; academic health centers and area health education centers; hospitals; and such other public or nonprofit agencies, institutions, or organizations as the Administrator deems appropriate.

It further provides that for the fiscal year ending June 30, 1972, and for each fiscal year thereafter, there shall be included in the budget required to be submitted to Congress by section 201 of the Budget and Accounting Act, 1921 (31 U.S.C. 11) a separate line item showing the estimated expenditures by the Veterans' Administration during such fiscal year for the education and training of health manpower.

SECTION 4

This section would amend section 5001(c) of title 38, to provide that any new VA hospital shall be constructed in close proximity to a school of medicine or osteopathy which is accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education of the Department of Health, Education, and Welfare and which has agreed to affiliate with the Veterans' Administration through such hospital. Any new hospital would be required to include such classrooms, lecture facilities, laboratories, and other teaching space, facilities, aids, and beds as are necessary to make the hospital suitable for health manpower education and training in accordance with the purposes of the new chapter 82.

SECTION 5

This section would amend part III of title 38, by adding a new chapter 82 containing four subchapters. Subchapter I would provide for coordination with other programs; authorizations for appropriations; and general provisions.

New section 5061 provides that the Administrator and the Secretary of Health, Education, and Welfare shall coordinate the programs to be carried out.

New section 5062 would authorize $125 million for each of the next 5 fiscal years for entering into agreements and making grants pursuant to this chapter. Funds appropriated pursuant to this section shall remain available until expended. Not more than 2 percent of the funds appropriated pursuant to this section for any fiscal year may be used for administrative expenses in carrying out this chapter in such fiscal year.

New section 5063(a) would prohibit the Administrator from entering into any agreements after the sixth calendar year in which this chapter takes effect.

New section 5063(b) prohibits the Administrator from entering into any agreement under subchapter III or making any grant under subchapter IV of this chapter without prior consultation of an advisory subcommittee established as part of the special medical advisory group under section 4112 of this section.

New section 5063(c) provides that the Administrator will ensure that qualified persons separated or discharged from military service shall be given priority for admission to health manpower and training programs. Those qualified persons who served during the Vietnam era and those entitled to VA disability compensation shall be given the highest priority.

New section 5063(d) provides that the Administrator shall prescribe regulations covering the agreements and grants to be made.

Subchapter II would provide for the expansion of Veterans' Administration hospital education and training capacity.

New section 5064 provides that the Administrator may spend such sums as he deems necessary, not to excede 30 percent thereof, for (A) the necessary extension, expansion, alteration, improvement, remodeling, or repair of Veterans' Administration buildings and structures to the extent necessary to make them suitable for the use of health manpower education and training, and for (B) special allocations to Veterans' Administration hospitals for the development or initiation of improved methods of education and training.

Subchapter III provides a pilot program for assistance in the establishment of new public nonprofit medical, health professions, and allied health schools and area health education centers.

New section 5065 authorizes the Administrator in consultation with the Secretary of Health, Education, and Welfare to implement a pilot program under which he may provide assistance in the establishment of new public nonprofit health professional and allied health schools, and area health education centers.

New section 5066 defines the following terms: (1) area health education center means a public nonprofit educational facility or other public nonprofit institution affiliated with a Veterans' Administration hospital for the conduct of or the providing of guidance for education and training programs for health manpower in association with State, community, or other nonprofit colleges or universities, other hospitals and health facilities, or professional health or medical organizations in a particular geographical area to serve as an instrument of cooperation between the medical school and its education, research, and health service programs and the framework of health facilities and organizations and activities for the betterment of health in a given area; (2) health professions school includes any public nonprofit school of medicine, osteopathy, dentistry, nursing, pharmacy, optometry, podiatry or public health which is, or there is reasonable assurance will be, accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education of the Department of Health, Education, and Welfare; (3) state means the several States, the District of Columbia, and the Commonwealth of Puerto Rico.

New section 5067(a) sets forth the assistance which the Administrator subject to subsection (b) of this section in consultation with the Secretary of Health, Education, and Welfare may provide a public nonprofit college or university in establishing a new health profession or allied health school or an area health education center:

(1) The leasing to the college or university for nominal or no consideration land building and structure under the control and jurisdiction as may be necessary for the establishment of such school or center, under such terms and conditions as the Administrator deems appropriate. Any lease made pursuant to this subchapter to any public or nonprofifit organization may be made without regard to the provisions of section 3709 of the Revised Statutes (41 U.S.C. 5). Notwithstanding section 321 of the act entitled "An Act making appropriations for the Legislative Branch of the Government for the fiscal year ending June 30, 1933, and for other purposes," approved June 30, 1932 (40 U.S.C. 303b), or any other provision of law, a lease made pursuant to this subchapter to any public nonprofit organization may provide for the maintenance, protection, or restoration, by the lessee, of the property leased, as a part or all of the consideration for the lease.

(2) The extension, alteration, improvement, remodeling or repair of buildings and structures to make them suitable for use as a health profession school or health education center facility.

(3) The payment of grants to reimburse the college or university in part for the cost of salaries of a faculty of such school or center subject to certain time and percentage of cost limitations.

New section 5067(b) prohibits the Administrator from entering into any agreement unless he finds that—

(A) the college or university has declared its clear intention and submitted a plan to the Administrator providing its share of the financial support for the proposed institution.

(B) the overall plans for the school or center must meet appropriate professional and other standards as the Administrator deems appropriate in consultation with the Secretary of Health, Education, and Welfare as to the education and training programs and include significant programs for (i) interdisciplinary training among health professionals and allied health schools, and (ii) training for new roles, types, or levels of health manpower and recruiting, enrolling, and retraining of qualified individuals who due to socioeconomic factors are financially or educationally disadvantaged; (iii) the school or center will maintain such arrangements with the Veterans' Administration medical facility with which it is associated (including but not limited to such arrangements as may be made under chapter IV of chapter 81 of this title) as will be mutually beneficial in the carrying out of the mission of the medical facility and the school or center; and (iiii) with regard to health professions and allied health schools, after consultation with the appropriate accreditation body or bodies approved for such purpose by the Commissioner of Education of the Department of Health, Education, and Welfare, there is reasonable assurance that, with the aid of an agreement under subsection (a) of this section, such school will meet the accreditation standards of such body or bodies within a reasonable time.

Subchapter IV would authorize assistance to affiliated medical, health professions, and allied health schools and other health manpower training institutions, and area health education centers.

New section 5071 declares that the Administrator in consultation with the Secretary of Health, Education, and Welfare is authorized to carry out a program of grants for eligible health manpower training institutions and area health education centers which maintain affiliations with the Veterans' Administration in order to assist such institutions or centers to expand and improve their capacities to train health manpower.

New section 5072 defines eligible institution as any public or private nonprofit—

(1) health professions school of the type defined in section 5066(b) of this title,

(2) area health education center of the type defined in section 5066(a) of this title, or

(3) institution for the training or education of allied health or other health personnel, which maintains an affiliation with the Veterans' Administration.

New section 5073(a) sets forth provisions allowing eligible institutions to apply for grants to carry out projects and programs. New section 5073(b) provides that the application for a grant under this section may be approved by the Administrator in consultation with the Secretary of Health, Education, and Welfare upon his finding that—

(1) The proposed projects and programs for which the grant will be made will make a significant contribution to improving the education or training program of the eligible institution and will result in a substantial increase in such students trained at such an institution;

(2) That the increase in the number of students will not threaten any existing accreditation or otherwise compromise the quality of the training at that institution;

(3) The application sets forth necessary fiscal control and accounting procedures;

(4) The application shall contain such information as the Administrator may require to carry out his functions under this subchapter;

(5) The application sets forth significant programs for the education of health personnel.

New section 5074 provides that payments made pursuant to grants under this subchapter may be made in installments, and in advance or by way of reimbursement in installments and in advance or by way of reimbursements with necessary adjustments on account of overpayments or underpayments as the Administrator may determine. New section 5074(b) amends the table of parts and chapters at the beginning of title 38 to provide chapter 82 immediately below chapter 81.

SECTION 6

This section of the bill provides that during the 2-year period immediately following the date of the enactment of this act, no part of any real property which is under the jurisdiction of the Administrator of Veterans' Affairs on the date of enactment of this act shall be determined to be excess to the needs of the Veterans' Administration or transferred or otherwise disposed of pursuant to any provision of the Federal Property and Administrative Services Act of 1948.

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, D.C., August 17, 1971.

Hon. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs,
Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your requests for the views of this office on H.J. Res. 748 and S.J. Res. 128 (July 28, 1971), and S. 2219 (July 2, 1971).

The indicated purpose of these legislative proposals is to expand the health manpower pool of the Nation primarily by authorizing the Veterans' Administration to make grants for (1) assisting affiliated medical schools and establishing new medical schools, and (2) training of various types of health personnel, including health paraprofessionals.

In its reports to the committee on these proposals, the Veterans' Administration strongly opposes their enactment. The VA points out that the grants which they would authorize would duplicate and overlap existing authorities under which the Department of Health, Education, and Welfare provides grant assistance to new and existing schools of medicine and assists in the training of allied health professionals.

The VA also points out that the President's health message to the Congress of February 18, 1971, included recommendations dealing with the Nation's health manpower needs. Those recommendations approach the problem of health manpower supply in a comprehensive manner, whereas the proposals covered by this report would have the contrary result of further fragmentation of effort.

We note, further, that S. 2219 contains a section that would prohibit, for a 2-year period, any real property under the jurisdiction of the VA from being determined to be excess to the needs of the VA or transferred or otherwise disposed of under the Federal Property and Administrative Services Act of 1949. In its report, the VA indicates that the provisions of this section "impose an undue and unnecessary limitation on the authority of the executive branch of the Government to dispose of real property excess to the present and future needs of the Federal Government."

We concur in the views expressed in the reports of the VA and, accordingly, strongly oppose enactment of H.J. Res. 748, S.J. Res. 128, and S. 2219.

Sincerely,

WILFRED H. ROMMEL,
Assistant Director for Legislative Reference.

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C., October 6, 1971.

Hon. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: By letter received here on August 20, 1971, you requested our comments on S. 2219, which, if enacted, would be cited as the "Veterans' Administration Health Manpower Training Act of 1971."

The purpose of S. 2219 is to amend title 38 of the United States Code to authorize the Administrator of Veterans' Affairs to (1) provide certain assistance in the establishment of new public nonprofit medical, health professions, and allied health schools, and (2) expand and improve health manpower training programs in Veterans' Administration (VA) facilities and in existing educational institutions affiliated with VA.

The proposed new chapter 82 of title 38, however, does not authorize access to the records of recipients of financial assistance by the Comptroller General. We recommend that such authority be provided with respect to recipients of funds under the proposed legislation. See sections 5067 and 5073. This could be accomplished by inserting the following new section 5064 in subchapter I and renumbering the proposed sections 5064 through 5074:

"§ *5064 Audit and Records*

"(a) Each recipient of assistance under this chapter shall keep such records as the Administrator may prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such assistance, the total cost of the project or undertaking in connection with which such assistance is made or used, the amount of that portion of the cost of the project or undertaking supplied by other sources, and such records as will facilitate an effective audit.

"(b) The Administrator and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipient of any assistance under this chapter which are pertinent to such assistance."

Section 5062 authorizes appropriations for carrying out chapter 32. The last sentence in that section provides that: "Not more than 2 percent of the funds appropriated for any fiscal year may be used for administrative expenses in carrying out [chapter 32] in such fiscal year." It is our view that the authorization and appropriation process, in which specific dollar requests from the VA for administrative expenses are reviewed each fiscal year by the appropriate congressional committees, provides the Congress with the opportunity to make realistic evaluations of the amounts necessary for program administration and, if desired, to set dollar limitations on the amounts that may be expended therefor. Accordingly, we recommend that the last sentence in section 5062 (lines 4–7, page 7) be deleted.

Sincerely yours,

ROBERT F. KELLER,
Deputy Comptroller General of the United States.

92D CONGRESS
1ST SESSION

S. 2354

IN THE SENATE OF THE UNITED STATES

JULY 27 (legislative day, JULY 26), 1971

Mr. CRANSTON introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38 of the United States Code to provide improved and expanded medical and nursing home care to veterans; to provide hospital and medical care to certain dependents and survivors of veterans; to provide for improved structural safety of Veterans' Administration facilities; to improve recruitment and retention of career personnel in the Department of Medicine and Surgery; and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the Veterans Health Care Reform Act of 1971".

II

TITLE I—HOSPITAL, DOMICILIARY, AND MEDICAL CARE BENEFITS

SEC. 101. (a) Subparagraph (C) of section 601 (4) of title 38, United States Code, is amended to read as follows:

"(C) private facilities for which the Administrator contracts in order to provide (i) hospital care or medical services for persons suffering from service-connected disabilities or from disabilities for which such persons were discharged or released from the active military, naval, or air service; (ii) hospital care for women veterans of any war; (iii) hospital care for veterans of any war in a State, Territory, Commonwealth, or possession of the United States not contiguous to the forty-eight contiguous States, except that the annually determined average hospital patient load per thousand veteran population hospitalized at Veterans' Administration expense in Government and private facilities in each such noncontiguous State may not exceed the average patient load per thousand veteran population hospitalized by the Veterans' Administration within the forty-eight contiguous States, but authority under this clause (iii) shall expire on December 31, 1978; or (iv) hospital care or medical services for the wife or child of a veteran who has a total disability, permanent in nature, resulting from a service-connected disability."

(b) Section 601 (5) of such title is amended to read as follows:

"(5) The term 'hospital care' includes—

"(A) (1) medical services rendered in the course of the hospitalization of any veteran, and (2) transportation and incidental expenses for any veteran who is in need of treatment for a service-connected disability or is unable to defray the expense of transportation;

"(B) such medical services, consultation, professional counseling, and training, including necessary expenses for transportation and subsistence, of the members of the immediate family (including legal guardians) of a veteran or a dependent or survivor of a veteran, or, in the case of a veteran or dependent or survivor of a veteran who has no such immediate family members (or legal guardian), the person in whose household such veteran, or a dependent or survivor certifies his intention to live, as may be necessary or appropriate to the effective treatment and rehabilitation of a veteran or a dependent or a survivor of a veteran; and

"(C) (1) medical services rendered in the course of the hospitalization of a dependent or survivor of a veteran, and (2) transportation and incidental expenses for a dependent or survivor of a veteran who is in need of treatment for any injury, disease, or disability and is unable to defray the expense of transportation."

SEC. 102. Section 610 of such title is amended by—

(1) inserting ", including direct admission for nursing home care," immediately after "hospital care" the first time it appears therein;

(2) striking out clause (1) (B) of subsection (a) and inserting in lieu thereof the following:

"(B) any veteran for a non-service-connected disability if he is unable to defray the expenses of necessary hospital care;"; and

(3) amending subsection (c) to read as follows:

"(c) While any veteran is receiving hospital care in any Veterans' Administration facility, the Administrator may, within the limits of Veterans' Administration facilities, furnish medical services to correct or treat any non-service-connected disability of such veteran, in addition to treatment incident to the disability for which he is hospitalized, if the veteran requests such services and the Administrator finds such services to be reasonably necessary to protect the health of such veteran."

(4) adding at the end thereof the following new subsection as follows:

"(d) The Administrator, within the limits of Veterans' Administration facilities, may furnish hospital care, including direct admission for nursing home care, to the following individuals to the extent that he determines, in accordance with regulations he shall prescribe, that the provision of such care does not interfere with the furnishing of hospital and domiciliary care under subsections (a) and (b) of this section:

"(1) the wife or child of a veteran who has a total disability, permanent in nature, resulting from a service-connected disability; and

"(2) widows and children entitled to death compensation or dependency and indemnity compensation under this title."

SEC. 103. (a) Subsection (a) of section 612 of such title is amended to read as follows:

"(a) Except as provided in subsection (b), the Administrator, within the limits of Veterans' Administration facilities, may furnish such medical services as he finds to be reasonably necessary to—

"(1) any veteran for a service-connected disability;

"(2) any veteran for a non-service-connected disability if the veteran has a service-connected disability other than a dental condition or disability which is not compensable in degree;

"(3) (A) the wife or child of a veteran who has a total disability, permanent in nature, resulting from a service-connected disability; and (B) widows and children entitled to death compensation or dependency and indemnity compensation under this title and;

"(4) any veteran for a non-service-connected disability (excluding first-aid or dispensary services for minor illnesses or injuries) which is determined to be in need of prompt medical attention under regulations which the Administrator shall prescribe.

Notwithstanding the foregoing provisions of this subsection, services may be furnished under clauses (3) and (4) of this subsection only to the extent that the Administrator determines, in accordance with regulations he shall prescribe, that such services do not interfere with the furnishing of such services to veterans under clauses (1) and (2). In the case of any veteran discharged or released from the active military, naval, or air service for a disability incurred or aggravated in line of duty, such services may be so furnished for that disability, whether or not service-connected for the purposes of this chapter."

(b) Subsection (f) of section 612 of such title is amended—

(1) by inserting ", by fee or contract," immediately after "services" in the material preceding clause (1); and

(2) by deleting "of any war" in clause (3).

SEC. 104. Section 620 of title 38, United States Code, is amended by adding at the end thereof a new subsection as follows:

"(d) For purposes of this section, the term 'veteran' shall include any person who has been furnished care in any hospital of the Armed Forces and who upon discharge or release therefrom will become a veteran."

SEC. 105. Section 626 of title 38, United States Code, is amended by striking out "fire" and inserting in lieu thereof "fire, earthquake, or other natural disaster".

TITLE II—AMENDMENTS TO CHAPTER 73 OF TITLE 38, UNITED STATES CODE, RELATING TO THE DEPARTMENT OF MEDICINE AND SURGERY

SEC. 201. Section 4101 of title 38, United States Code, is amended by adding at the end thereof the following new subsections:

"(c) In order to utilize personnel within the Department of Medicine and Surgery more effectively, the Administrator shall carry out a continuing study of, and take appropriate action to implement, new and improved methods of rendering health care services through, but not limited to, reassignment of duties as between medical, allied, professional, technical or other health personnel; through the establishment of new positions such as physicians' and dentists' assistants; through the establishment of programs for continuing education (and granting of academic credit therefor) of all health personnel; by providing maximum mobility between health personnel positions; and through the use of electronic, automated, computerized, or other mechanical devices.

"(d) In order to attain comparability in the staff-to-patient ratio in Veterans' Administration hospitals with other public hospitals and with private hospitals, the Administrator shall, on a geographic or regional area basis, select as an index for such purpose any hospital (or other medical installation having hospital facilities) having an optimum staff-to-patient ratio. Within three years after the date of the enactment of this subsection, the staff-to-patient ratio at each Veterans' Administration hospital, domiciliary, and clinic shall be comparable to that of the index facility in such area at such time, taking into consideration the composition of patient population. To secure the information and statistical data necessary for the selection of such index hospital, the Administrator may make arrangements, by contract or other form of agreement, for such medical information services. The Administrator shall submit to the Congress, not more than sixty days after the end of each fiscal year, a report describing the actions taken to implement the provisions of this subsection and the extent to which such provisions have been implemented. Such report shall also include a facility-by-facility description of established staff-to-patient ratios."

SEC. 202. Section 4103 (a) of title 38, United States Code, is amended—

(1) by amending paragraph (4) to read as follows:

"(4) Not to exceed eight Assistant Chief Medical Directors, who shall be appointed by the Administrator upon the recommendations of the Chief Medical Director. At least two Assistant Chief Medical Directors may be individuals qualified in the administration of health services who are not doctors of medicine, dental surgery, or dental medicine. One assistant Chief Medical Director shall be a qualified doctor of dental surgery or dental medicine who shall be directly responsible to the Chief Medical Director for the operation of the Dental Service."; and

(2) by amending paragraph (7) to read as follows:

"(7) A Director of Pharmacy Service and a Director of Dietetic Service, appointed by the Administrator."

SEC. 203. The text of section 4104 of title 38, United States Code, is amended to read as follows:

"There shall be appointed by the Administrator additional personnel as he may find necessary to carry out the functions defined in section 4101 of this title, as follows:

"(1) physicians, dentists, and nurses;

"(2) allied professional health care and scientific personnel for which the Administrator determines that a minimum of a baccalaureate degree (or its equivalent) in such a profession is required;

"(3) physicians' assistants, and dentists' assistants; and

"(4) health technician personnel, such as medical technicians, medical radiology technicians, licensed practical nurses, nursing assistants and other personnel (except clerical, administrative, and physical plant maintenance and protective personnel, and persons paid under section 5341 of title 5, United States Code) determined by the Administrator as performing services incident, subordinate, or preparatory to the services required of persons appointed under clause (1), (2), or (3) of this section."

SEC. 204. Section 4105 of title 38, United States Code, is amended by—

(1) striking out the period at the end of subsection (a) (7) and inserting in lieu thereof a semicolon;

(2) adding at the end of such subsection (a) a new paragraph as follows:

"(8) Physicians' assistants and dentists' assistants shall have such medical or dental and technical qualifications and experience as the Administrator shall prescribe."; and

(3) striking out in subsection (b) "as a physician, dentist, or nurse" and inserting in lieu thereof "under section 4104 of this title".

SEC. 205. Section 4106 of title 38, United States Code, is amended by—

(1) striking out in subsection (a) "and nurses" and inserting in lieu thereof "nurses, allied professional health care and scientific personnel, physicians' assistants, dentists' assistants, and health technician personnel";

(2) (A) striking out in subsection (b) "(b) Such

appointments" and inserting in lieu thereof "(b) (1) Appointments of physicians, dentists, and nurses", and

(B) adding at the end of subsection (b) a new paragraph (2) as follows:

"(2) Appointments of allied professional health care and scientific personnel, physicians' assistants, dentists' assistants, and health technician personnel made pursuant to paragraphs (2), (3), and (4) of section 4104 of this title shall be made without regard to those provisions of title 5 governing appointments in the competitive service and those provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates. The Administrator shall provide by regulation for benefits equivalent to those provided by sections 5333 through 5337 of title 5.";

(3) striking out in subsection (c) "and nurses" and inserting in lieu thereof "nurses, allied professional health care and scientific personnel, physicians' assistants, dentists' assistants, and health technician personnel"; and

(4) striking out in subsection (e) "or nurse" and inserting in lieu thereof "nurse, allied professional health care or scientific employee, physician's assistant, dentist's assistant, or health technician employee".

SEC. 206. (a) Subsections (a) and (b) of section 4107 of title 38, United States Code, are amended to read as follows:

"(a) (1) The per annum full-pay scale or ranges for positions provided in section 4103 of this title, other than Chief Medical Director and Deputy Chief Medical Director, shall be as follows:

"Section 4103 Schedule

"Associate Deputy Chief Medical Director, $36,000.

"Assistant Chief Medical Director, $37,624.

"Medical Director, $32,546 minimum to $36,886 maximum.

"Director of Nursing Services, $32,546 minimum to $36,886 maximum.

"Director of Chaplain Service, $28,129 minimum to $35,633 maximum.

"Director of Pharmacy Service, $28,129 minimum to $35,633 maximum.

"Director of Dietetic Service, $28,129 minimum to $35,633 maximum.

"(2) The provisions of section 5308 of title 5, United States Code, shall apply to payments made under this subsection.

"(b) (1) The grades and per annum full-pay ranges for positions provided for in paragraph (1) of section 4104 of this title shall be as follows:

"Physician and Dentist Schedule

"Director grade, $28,129 minimum to $35,633 maximum.

"Executive grade, $26,143 minimum to $33,982 maximum.

"Chief grade, $24,251 minimum to $31,523 maximum.

"Senior grade, $20,815 minimum to $27,061 maximum.

"Intermediate grade, $17,761 minimum to $23,089 maximum.

"Full grade, $15,040 minimum to $19,549 maximum.

"Associate grade, $12,615 minimum to $16,404 maximum.

"Nurse Schedule

"Director grade, $24,251 minimum to $31,523 maximum.

"Assistant Director grade, $20,815 minimum to $27,061 maximum.

"Chief grade, $17,761 minimum to $23,089 maximum.

"Senior grade, $15,040 minimum to $19,549 maximum.

"Intermediate grade, $12,615 minimum to $16,404 maximum.

"Full grade, $10,470 minimum to $13,611 maximum.

"Associate grade, $9,026 minimum to $11,735 maximum.

"Junior grade, $7,727 minimum to $10,049 maximum.

"(2) Notwithstanding the foregoing, nurses shall be entitled to receive additional compensation as provided in subsection (h) of this section.

"(3) No person may hold the director grade in the 'Physician and Dentist Schedule' unless he is serving as a director of a hospital, domiciliary, center, or outpatient clinic (independent). No person may hold the executive grade unless he holds the position of chief of staff at a hospital, center, or outpatient clinic (independent), or comparable position."

(b) Subsection (c) of section 4107 of such title is amended by redesignating subsection (c) as subsection (e), and by inserting after subsection (b) of such section the following new subsections:

"(c) (1) The grades and per annum full-pay ranges for positions provided for in paragraphs (2) and (3) of section 4104 of this title shall be as follows:

"Allied Professional Schedule

"AP grade 8, $28,129 minimum to $35,633 maximum.
"AP grade 7, $24,251 minimum to $31,523 maximum.
"AP grade 6, $20,815 minimum to $27,061 maximum.
"AP grade 5, $17,761 minimum to $23,089 maximum.
"AP grade 4, $15,040 minimum to $19,549 maximum.
"AP grade 3, $12,615 minimum to $16,404 maximum.
"AP grade 2, $10,470 minimum to $13,611 maximum.

"AP grade 1, $8,582 minimum to $11,156 maximum.

"(2) Notwithstanding the foregoing, physicians' and dentists' assistants shall not be paid less than the AP grade 2 minimum.

"(d) (1) The grades and per annum full-pay ranges for positions provided for in paragraph (4) of section 4104 of this title shall be as follows:

"Health Technician Schedule

"HT grade 9, $15,040 minimum to $19,549 maximum.
"HT grade 8, $12,615 minimum to $16,404 maximum.
"HT grade 7, $10,470 minimum to $13,611 maximum.
"HT grade 6, $9,493 minimum to $12,337 maximum.
"HT grade 5, $8,582 minimum to $11,156 maximum.
"HT grade 4, $7,727 minimum to $10,049 maximum.
"HT grade 3, $6,938 minimum to $9,017 maximum.
"HT grade 2, $6,202 minimum to $8,065 maximum.
"HT grade 1, $5,524 minimum to $7,180 maximum.

"(2) Notwithstanding the foregoing, licensed practical nurses and nursing assistants shall be entitled to receive additional compensation as provided in subsection (h) of this section."

(c) Section 4107 of such title is further amended by adding at the end thereof the following new subsections:

"(f) With respect to physicians appointed pursuant to section 4104(1) of this title, the Administrator, upon the recommendation of the Chief Medical Director may increase the per annum salary of a physician who performs administrative duties within the Department by an amount not to exceed 20 per centum of such salary, but in no event shall the combination of salary and allowances under this subsection exceed the salary prescribed for level V of the Executive Schedule under section 5316 of title 5.

"(g) When he finds such action to be necessary in order to obtain or retain the services of physicians, dentists, nurses, allied professional health care and scientific personnel, physicians' assistants, dentists' assistants, or health technician personnel to provide medical care and treatment for veterans, the Administrator, notwithstanding any other provision of law, shall increase the maximum rates of pay authorized under subsection (b) of this section, on a nationwide, local, or other geographic basis, for one or more grades or for one or more medical fields within the grades, to provide pay commensurate with competitive pay practices or to meet at remote stations the staff-to-patient ratios provided for in section 4101 (d) of this title. Any such increase in the maximum rate for any grade may not exceed in corresponding amount, the amount provided for in the statutory range for that grade, nor exceed the rate established for Assistant Chief Medical Director under the 'section 4103 schedule' set forth in subsection (a) of this section.

"(h) (1) Pursuant to regulations prescribed by him, the Administrator shall pay nurses, licensed practical nurses, and nursing assistants (hereinafter referred to as "nurses") paid pursuant to the schedules prescribed in subsections (b) (1) and (d) (1) of this section additional pay as provided in this subsection for duty performed in the evening, at night, on Saturday, Sunday, or a holiday, or for duty performed in excess of regular daily or weekly schedules.

"(2) For the purposes of this subsection, a nurse's hourly rate of pay shall be determined by dividing her annual rate of pay by 2080.

"(3) Any nurse performing duty on the evening tour of duty or the night tour of duty which is compensable under such nurse schedule shall be paid additional pay at a rate not exceeding 15 per centum of her hourly rate of pay for the period of such duty.

"(4) Any nurse performing duty on Saturday which is compensable under such nurse schedule shall be paid additional pay at a rate not exceeding 20 per centum of her hourly rate of pay for the period of such duty.

"(5) Any nurse performing duty on Sunday which is compensable under such nurse schedule shall be paid additional pay at a rate not exceeding 30 per centum of her hourly rate of pay for the period of such duty.

"(6) When any nurse is entitled to additional pay under both paragraphs (3) and (4) or both paragraphs (3) and (5) for the same period of duty, the amounts of such additional pay shall be computed separately on the basis of her hourly rate of pay only.

"(7) Any nurse performing duty on a legal public holiday which is compensable under such nurse schedule shall be paid additional pay at a rate not exceeding 100 per centum of her basic hourly rate of pay for the period of such duty.

"(8) Any nurse performing duty compensable under such nurse schedule in excess of her regularly scheduled hours during a workday (other than a regularly scheduled holiday) shall be paid additional pay at a rate not exceeding 150 per centum of her basic hourly rate of pay for the period of such excess duty.

"(9) Any nurse performing duty compensable under such nurse schedule on the sixth or seventh day of her workweek shall be paid additional pay at a rate not exceeding 150 per centum of her hourly rate of pay for the period of such duty. Such hourly rate of pay shall include the rate of any amount of additional pay under paragraph (3) for such sixth or seventh day.

"(10) When any nurse is entitled to additional pay under paragraph (9) she shall not be entitled to additional pay under paragraph (4), (5), (7), or (8) for the same period of duty.

"(11) Any additional compensation paid pursuant to this subsection shall not be considered as basic compensation for the purposes of subchapter VI and section 5595 of subchapter IX of chapter 55, chapter 81, 83, or 87 of title 5, or other benefits based on basic compensation.

"(12) The Administrator shall, on request of a nurse, and to the extent patient care needs will permit, grant the nurse compensatory time off from her scheduled tour of duty instead of additional pay for an equivalent amount of time to which she would be entitled under paragraph (3), (4), (5), (7), (8), or (9)."

SEC. 206. Section 4109 of title 38, United States Code, is amended—

(1) by inserting "(a)" immediately before "Persons";

(2) by striking out "the Civil Service Retirement Act" and inserting in lieu thereof "chapter 83 of title 5"; and

(3) by adding at the end thereof the following new subsection:

"(b) Each physician and dentist employed in the Veterans' Administration for a period of twenty years or more shall be credited with a period of time as service for the purposes of retirement under chapter 83 of title 5 equal to the period of time determined by the Administrator to have been devoted—

"(1) by such physician to the pursuit of the degree of doctor of medicine or doctor of osteopathy, or

"(2) by such dentist to the pursuit of the degree of doctor of dental surgery or doctor of dental medicine.

Each such physician or dentist shall, in addition, be credited with a period of time as service for such purposes, equal to the time determined by the Administrator to have been devoted by such physician or dentist to a full-time internship in his profession. However, no physician or dentist may be credited with a period of more than five years under the provisions of this subsection. Further, such period shall be reduced by the period of active military, naval, or air service or other Federal service performed by such physician or dentist during the pursuit of his degree or performance of internship in his profession."

SEC. 207. Section 4111 of title 38, United States Code, is amended by striking out "paragraph (1) of".

SEC. 208. Section 4113 of title 38, United States Code, is amended by striking out "paragraph (1) of".

SEC. 209. Section 4114 of title 38, United States Code, is amended as follows:

(1) by striking out in subsection (a) (2) "paragraph (1) of";

(2) by amending subsection (a) (3) to read as follows:

"(3) (A) Temporary full-time appointments of physicians, dentists, nurses, allied professional health care and scientific personnel, physicians' and dentists' assistants, and health technician personnel may exceed ninety days only if the Chief Medical Director finds that circumstances render it impracticable to obtain the necessary services through appointments under section 4104 of this title. Temporary full-time appointments of persons who have successfully completed a full course of nursing in a recognized school of nursing, approved by the Administrator, and are pending registration as a graduate nurse in a State, shall not exceed one year.

"(B) No part-time appointments shall be for a period of more than one year, except for appointments of physicians, dentists, nurses, allied professional health care and scientific personnel, physicians' and dentists' assistants, health technician personnel, interns, and residents and other trainees in medical support programs."; and

(3) by inserting "(1)" immediately after "(b)" at the beginning of subsection (b) of such section and

by adding at the end of such subsection a new paragraph as follows:

"(2) In order to carry out more efficiently the provisions of paragraph (1) of this subsection, the Administrator may contract with one or more hospitals, medical schools, or medical installations having hospital facilities and participating with the Veterans' Administration in the training of interns or residents to provide for the central administration of stipend payments, provision of fringe benefits, and maintenance of records for such interns and residents by the designation of one such institution to serve as an agency for this purpose. The Administrator may pay to such designated central administrative agency, without regard to any other law or regulation governing the expenditure of Government moneys either in advance or in arrears, an amount to cover the cost for the period such intern or resident serves in a Veterans' Administration hospital of (A) such stipends as fixed by the Administrator pursuant to paragraph (1) of this subsection, (B) hospitalization, medical care, and life insurance, and any other employee benefits as are agreed upon by the participating institutions for the period that such intern or resident serves in a Veterans' Administration hospital, (C) tax on employers pursuant to chapter 21 of the Internal Revenue Code of 1954, where applicable, and in addition, (D) an amount to cover a pro rata share of the cost of expense of such central administrative agency. Any amounts paid by the Administrator to such fund to cover the cost of hospitalization, medical care, or life insurance or other employee benefits shall be in lieu of any benefits of like nature to which such intern or resident may be entitled under the provisions of title 5, and the acceptance of stipends and employee benefits from the designated central administrative agency shall constitute a waiver by the recipient of any claim he might have to any payment of stipends or employee benefits to which he may be entitled under this title or title 5. Notwithstanding the foregoing, any period of service of any such intern or resident in a Veterans' Administration hospital shall be deemed creditable service for the purposes of section 8332 of title 5. The agreement may further provide that the designated central administrative agency shall make all appropriate deductions from the stipend of each intern and resident for local, State, and Federal taxes, maintain all records pertinent thereto and make proper deposits thereof, and shall maintain all records pertinent to the leave accrued by each intern and resident for the period during which he serves in a participating hospital, including a Veterans' Administration hospital. Such leave may be pooled, and the intern or resident may be afforded leave by the hospital in which he is serving at the time the leave is to be used to the extent of his total accumulated leave, whether or not earned at the hospital in which he is serving at the time the leave is to be afforded.".

SEC. 210. Section 4116 of title 38, United States Code, is amended—

(1) by amending subsection (a) to read as follows:

"(a) The remedy—

"(1) against the United States provided by sections 1346 (b) and 2672 of title 28, or

"(2) through proceedings for compensation or other benefits from the United States as provided by any other law, where the availability of such benefits precludes a remedy under sections 1346 (b) or 2672 of title 28,

for damages for personal injury, including death, allegedly arising from malpractice or negligence of a physician, dentist, nurse, pharmacist, or paramedical (for example, medical, and dental technicians, nursing assistants, and therapists) or other supporting personnel in furnishing medical care or treatment while in the exercise of his duties in or for the Department of Medicine and Surgery shall hereafter be exclusive of any other civil action or proceeding by reason of the same subject matter against such physician, dentist, nurse, pharmacist, or paramedical or other supporting personnel (or his estate) whose act or omission gave rise to such claim.";

(2) by striking out the last sentence in subsection (c) and inserting in lieu thereof the following: "After removal the United States shall have available all defenses to which it would have been entitled if the action had originally been commenced against the United States. Should a United States district court determine on a hearing on a motion to remand held before a trial on the merits that the employee whose act or omission gave rise to the suit was not acting within the scope of his office or employment, the case shall be remanded to the State court."; and

(3) by adding at the end thereof a new subsection as follows:

"(e) The Administrator may, to the extent he deems appropriate, hold harmless or provide liability insurance for any person to which the immunity provisions of this section apply (as described in subsection (a)), for damage for personal injury or death, or for property damage, negligently caused by such person while furnishing medical care or treatment (including the conduct of clinical studies or investigations) in the exercise of his duties in or for the Department of Medicine and Surgery, if such person is assigned to a foreign country, detailed to a State or political division thereof, or is acting under any other circumstances which would preclude the remedies of an injured third person against the United States provided by sections 1346(b) and 2672 of title 28, for such damage or injury."

SEC. 211. The text of section 4117 of title 38, United States Code, is amended to read as follows:

"The Administrator may enter into contracts to provide scarce medical specialist services at Veterans' Administration facilities with medical schools, clinics, and any other group or individual capable of furnishing such services (including, but not limited to, services of physicians, dentists, nurses, technicians, and other medical support personnel)."

TITLE III—RELATING TO HOSPITAL AND DOMICILIARY FACILITIES; LEASING AUTHORITY OF THE ADMINISTRATOR; SPECIALIZED MEDICAL RESOURCES; USE OF EXCESS HOSPITAL BEDS; AND TELEPHONE SERVICE FOR CERTAIN MEDICAL OFFICERS

SEC. 301. (a) Subsection (a) of section 5001 of title 38, United States Code, is amended by—

(1) striking out the period at the end of paragraph (1) and inserting in lieu thereof a comma and the following: "and the Administrator shall maintain an average daily patient census in such beds of at least 84,500 patients";

(2) striking out in the first sentence of paragraph (3) "is authorized" and inserting in lieu thereof "shall", and by striking out "four thousand beds" and inserting in lieu thereof "six thousand beds, in the fiscal year ending June 30, 1972, eight thousand beds in the fiscal year ending June 30, 1973, and ten thousand beds in the fiscal year ending June 30, 1974, and each fiscal year thereafter";

(3) striking out the period at the end of the second sentence of paragraph (3) and inserting in lieu thereof a comma and the following: "except that the Administrator shall convert to nursing beds any hospital beds (in facilities over which the Administrator has direct and exclusive jurisdiction) which are not being adequately utilized for hospitalization purposes and which are located in structurally sound, functionally adequate, and fire, earthquake and other natural disaster resistant buildings, if the need for nursing beds cannot be satisfactorily met otherwise. Whenever any hospital bed has been converted to a nursing bed pursuant to this paragraph, such bed shall count against the total number of beds authorized under this paragraph and paragraph (2) of this subsection."

(b) Subsection (b) of section 5001 of such title is amended to read as follows:

"(b) Hospitals, domiciliaries, and other medical facilities provided by the Administrator shall be of fireproof and earthquake and other natural disaster resistant construction in accordance with standards which the Administrator shall prescribe on a State or regional basis after surveying appropriate State and local laws, ordinances, and building codes and climactic and seismic conditions pertinent to each such facility. When an existing plant is purchased, it shall be remodeled to comply with the requirements stated in the first sentence of this subsection. In order to carry out this subsection, the Administrator shall appoint an Advisory Committee on Structural Safety of Veterans' Administration Facilities, on which shall serve at least one architect and one structural engineer expert in fireproofing, earthquake, and other natural disaster resistance who shall not be employees of the Federal Government, to advise him on all matters of structural safety in the construction and remodeling of Veterans' Administration facilities in accordance with the requirement of this subsection, and which shall approve regulations prescribed thereunder. The Associate Deputy Administrator, the Assistant Administrator for Construction, and the Chief Medical Director, or his designee, shall be ex officio members of such committee."

SEC. 302. Section 5012 (a) of title 38, United States Code, is amended by inserting after the first sentence the following: "Any lease made pursuant to this subsection to any public or nonprofit organization may be made without regard to the provisions of section 3709 of the Revised Statutes (41 U.S.C. 5). Notwithstanding section 321 of the Act entitled 'An Act making appropriations for the Legislative Branch of the Government for the fiscal year ending June 30, 1933, and for other purposes', approved June 30, 1932 (47 Stat. 412; 40 U.S.C. 303b) or any other provision of law, a lease made pursuant to this subsection to any public or nonprofit organization may provide for the maintenance, protection, or restoration, by the lessee, of the property leased, as a part or all of the consideration for the lease."

SEC. 303. Section 5053 (a) of title 38, United States Code, is amended by striking out "or medical schools" at the beginning of the material contained in parentheses, and by inserting immediately after the close parenthesis the words "or medical schools or clinics".

SEC. 304. (a) Chapter 81 of such title is amended by inserting immediately after section 5053 a new section as follows:

"§ 5053A. Use of excess hospital beds

"In addition to the authority granted under section 5053 of this title, the Administrator may, when he determines it to be in the best interest of the prevailing standards of the

Veterans' Administration medical care program, make arrangements, by contract or other form of agreement, between Veterans' Administration hospitals and other hospitals (or other medical installations having hospital facilities) or medical schools or clinics in the medical community, for the use of Veterans' Administration hospital beds, with supporting services, when not needed for the care and treatment of veterans."

(b) The table of sections at the beginning of chapter 81 of such title is amended by inserting immediately after

"5053. Specialized medical resources."

the following:

"5053A. Use of excess hospital beds."

SEC. 305. Section 234 of title 38, United States Code, is amended by inserting immediately after the words "telephones for" the words "hospital and center directors and".

[From the Congressional Record—Senate—Tuesday, July 27, 1971]

S. 2354 VETERANS HEALTH CARE REFORM ACT OF 1971

Mr. CRANSTON. Mr. President, the Veterans' Administration Department of Medicine and Surgery plays a role unequaled in virtually all nations in providing American veterans with, in most instances, quality health care. The system of 165 hospitals—three soon to open—200 clinics, and 76 nursing homes with 150,000 staff physicians, nurses, and other health workers makes a good quality of medical care available to some 6 million eligible veterans.

However, there are limits on that availability of care, partly as a result of budgetary restrictions which create shortages of staff and equipment, and partly as a result of limited legislative authorities which make quality care impossible to deliver in many cases.

Mr. President, regarding the provision of adequate funds, we will shortly take up the conference report on H.R. 9382, including fiscal year 1972 appropriations for the Veterans' Administration. That bill now contains $204.1 million more than was in the President's budget request for the VA hospital and medical programs for this fiscal year. I will speak to this question further when we take up the conference report. Suffice it to say now that, with the great assistance of the Appropriations Subcommittee chairman (Mr. PASTORE) and ranking minority member (Mr. ALLOTT), and in collaboration with Chairman TEAGUE in the other body, we have succeeded over a 2 fiscal year period in increasing VA hospital and medical appropriations by almost $360 million over the President's original request for fiscal year 1971.

Furthermore, the potential increase in veterans in need of treatment for drug addiction, combined with the general aging and concomitant experiencing of medical complications of the veterans of the Second World War, places an additional burden on the Veterans' Administration hospital and medical system in terms of staff and facilities. The rapid technological improvements occurring constantly in the medical community place an additional requirement on the Veterans' Administration which, though leading in many of these areas, must keep its staff informed, and its equipment up to date with new techniques and treatment processes, as they are developed.

In order to assist the Veterans' Administration to meet this increasing demand with up-to-date medical care and technology, I am introducing today S. 2354, the proposed "Veterans Health Care Reform Act of 1971."

This comprehensive overhaul of VA medical authorities, including especially the personnel system of the Department of Medicine and Surgery, would provide the Veterans' Administration Department of Medicine and Surgery with most of the tools it needs to repair deficiencies in its basic enabling legislation. A number of the provisions of S. 2354 are virtually identical to provisions of S. 1924, which I joined with Senators HARTKE and THURMOND in introducing, by request, on behalf of the administration.

Comparable provisions of the two bills are shown on the chart that I ask unanimous consent be printed in the RECORD at the conclusion of my remarks prior to the printing of the bill.

In addition, S. 2354 provides for new authorities and expands and improves current ones, in a way I believe will enable the VA to attract and retain high-quality staff, to provide total health care to the veteran, and function in closer relationship to the surrounding medical community.

Many of these provisions are based on principles which I have suggested as basic guides to the VA medical program for the provision of first-quality care for veterans.

TREATING THE VETERAN AS PART OF A FAMILY UNIT

Broadening the treatment of the veteran to include a veteran's family, in certain instances, will fulfill the basic need particularly in psychiatry, of treating the individual as part of a family unit, not as an isolated individual removed from any family or social environment. Similarly, total care of a physically disabled veteran may require that his family be fully oriented on the philosophy of his rehabilitation program. The VA should be able to bring key family members to the hospital for his orientation, as is done now on a limited basis at some of the VA blind centers. with nonappropriated funds.

As a corollary of this concept, I believe the VA system should be more fully responsive to the medical needs of all veterans and their families. The bill provides full VA medical and hospital care for the dependents of totally and permanently disabled living veterans—including authority to contract for necessary services with individual physicians and health facilities—as well as hospital and medical services in VA facilities for survivors receiving disability and indemnity compensation.

These family provisions also would provide specific authority for the VA to stress home care programs for any hospitalized veteran. Although a start has been made by the VA in home kidney dialysis, much more needs to be done, especially in the psychiatric field. Most medical experts agree that institutional care is the least desirable. Alternatives could be fully explored under these provisions.

Home care—employing mobile teams to train families and conduct posthospital followup—can in many cases provide more compassionate, more effective and far more economical care.

TREATING THE PATIENT AS A "WHOLE" PATIENT

In line with the idea of total care, the bill would amend present restrictions on care for a non-service-connected condition unrelated to the condition for which a veteran was hospitalized. Clearly, a physician cannot ethically assume responsibility for only a portion of his patient's health, and the bill would authorize necessary medical care for any illness of a hospitalized veteran.

Along the same lines, the bill expands authorities for outpatient care for non-service-connected conditions to include necessary ambulatory care to any veteran having either peacetime or wartime service, for any disability which the Administrator determines needs prompt medical attention, under regulations which the Administrator must prescribe. However, such services may not interfere with the furnishing of such services to veterans for a service-connected disability or to a veteran for a non-service-connected disability if he has a service-connected disability.

RECOGNIZE NURSING HOME CARE AS PART OF HOSPITAL CARE

Another provision of the bill would permit veterans to apply for direct admission to a VA nursing home without prior VA hospitalization. The bill would also authorize the direct transfer of a veteran from a military medical facility to either a Veterans' Administration or a community nursing home. And the bill would also raise the present statutory minimum of 4,000 VA nursing home beds to 10,000 by fiscal year 1974. There is an unmet demand for VA nursing home beds by World War I veterans which will expand as our World War II veterans grow older. We should consider converting hospital beds not being fully utilized into VA nursing home beds. Community nursing homes are already greatly in demand among the aging nonveterans.

IMPROVED VA PERSONNEL SYSTEM

S. 2354 also would revise Department of Medicine and Surgery personnel authorities to enable the VA to compete more effectively for scarce health professionals. The VA must be able to enlarge its training program if it is ever going to make up its personnel shortages. A method authorized by S. 2354 permits the VA to pay special salary differentials for posts they are having difficulty filling, and to peg general salaries geographically to an index community hospital.

The bill would also require that every VA facility reach a comparable staff-to-patient ratio with an index community hospital wtihin 3 years. The present disparities are shocking: 1.5 for the VA general hospital, 2.7 for the average community hospital, and 3.5 to 4.0 for the university hospital; and that means inadequate care, inadequate attention, and inadequate time for the veterans in those hospitals.

CLOSER RELATIONSHIP WITH HIGH QUALITY NON-VA MEDICAL FACILITIES

To maintain the VA hospital and medical programs in the mainstream of medical advances, authority is provided for Veterans' Administration facilities to contract for scarce medical resources with a medical school whether or not it has a hospital, and with clinics. Current law requires that the medical school have hospital facilities before any sharing agreement can be made between the medical school and the Veterans' Administration. Authority is also expanded to include contracts with any group or individual capable of furnishing scarce medical specialist services.

In addition, new authority is granted to the Administrator to make arrangements for the utilization of excess Veterans' Administration hospital beds, with supporting services, when they are not needed for the care and treatment of veterans, by other hospitals or medical schools or clinics in the community.

STRUCTURAL SAFETY OF VA FACILITIES

The tragic consequences of a number of natural disasters within recent years has pointed to the need for stricter standards in the construction of Veterans' Administration facilities. These were the loss of lives due to earthquake damage at San Fernando, Calif., closely followed by a tornado at Fayetteville, N.C. Considerable numbers of veterans lost personal effects at the veterans facilities at Gulfport and Biloxi, Miss., as a result of damage caused by Hurricane Camille. S. 2354 provides that the Administrator shall prescribe construction standards on a State or regional basis for each VA facility, such standards to be based on a survey of pertinent State and local ordinances, building codes, climactic and seismic conditions, with the purpose of assuring that all hospitals, domiciliaries, and other medical facilities of the Veterans' Admnistration will be fireproof, and earthquake and other natural disaster resistant. Through such measures, future tragedies can be prevented.

The following sections of S. 1924 and S. 2354 are virtually identical:

S. 1924	S. 2354
Section 202	Section 202
Section 203	Section 206(a)
Section 206	Section 210
Section 207	Setcion 211
Section 301	Section 302
Section 302	Sections 303 and 304
Section 401	Section 305

[No. 39]

COMMITTEE ON VETERANS' AFFAIRS, UNITED STATES SENATE

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., September 23, 1971.

Hon. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs,
United States Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This will respond to your request for a report by the Veterans' Administration on S. 2354, 92d Congress, the "Veterans' Health Care Reform Act of 1971".

The purpose of the subject bill, as stated in its title, is to provide improved and expanded medical and nursing home care to veterans; to provide hospital and medical care to certain dependents and survivors of veterans; to provide for improved structural safety of Veterans' Administration facilities; and to improve recruitment and retention of career personnel in the Department of Medicine and Surgery.

In view of the large number of sections and the wide area of medical care and medical personnel administration covered by the bill, we are enclosing a detailed anaylsis of each section of the bill and the position of the Veterans' Administration thereon, together with the ascertainable costs.

As a purely technical matter, it is pointed out that the bill contains two sections numbered 206. The first begins on page 12, and the second begins on page 20. If the bill is to be given further consideration, the latter should be changed to 207 and the succeeding section of title II of the bill redesignated.

As indicated in the enclosure, we feel that several of the provisions of S. 2354 are unnecessary inasmuch as their objectives can be attained under existing law. Moreover, many of the provisions threaten to undermine our ability to provide an increasing quality of care to those veterans for whom we are primarily responsible by opening the VA system to large numbers of nonveterans. Many existing programs and recent presidential proposals for improving the financing and accessibility of health care for all citizens are a far more appropriate means of aiding the classes of beneficiaries which this bill would propose to add to the VA hospital system. In addition, coverage under the President's proposals for a National Health Insurance Partnership and a Family Health Insurance Program would be superior to the care provided to survivors and dependents by this bill in two major respects:

—It would give beneficiaries a choice of care in their communities; and

—It would provide preventive and maintenance health care.

Accordingly, we are strongly opposed to enactment of S. 2354 by your Committee.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Donald E. Johnson,
Administrator.

Enclosure.

SECTION-BY-SECTION ANALYSIS AND ESTIMATE OF COST OF S. 2354

"Veterans Health Care Reform Act of 1971"

TITLE I—HOSPITAL, DOMICILIARY AND MEDICAL CARE BENEFITS

Section 101

Subsection (a) of this section would amend subparagraph (C) of section 601(4), title 38, to reflect in the definition of "Veterans' Administration facilities" the longstanding statutory construction of the term to include private facilities for which the Administrator contracts to provide outpatient care for service-connected disabilities. It would also add authority for contract hospital and outpatient care for the wife or child of a veteran who has a total disability, permanent in nature from a service-connected disability.

Subsection (b) would amend section 601(5) to define the term "hospital care" to include:

(A) (1) medical services rendered in the course of the hospitalization of any veteran, and (2) transportation and incidental expenses for any veteran who is in need of treatment for a service-connected disability or is unable to defray the expense of transportation;

(B) such medical services, consultation, professional counseling, and training, including necessary expenses for transportation and subsistence, of the members of the immediate family (including legal guardians) of a veteran or a dependent or survivor of a veteran, or, in the case of a veteran or dependent or survivor of a veteran who has no such immediate family members (or legal guardian), the person in whose household such veteran, or a dependent or survivor certifies his intention to live, as may be necessary or appropriate to the effective treatment and rehabilitation of a veteran or a dependent or survivor of a veteran; and

(C) (1) medical services rendered in the course of the hospitalization of a dependent or survivor of a veteran, and (2) transportation and incidental expenses for a dependent or survivor of a veteran who is in need of treatment for any injury, disease, or disability and is unable to defray the expenses of transportation.

The amendment made by that portion of subsection (a) relating to the definition of VA facilities, with the exception of clause (iv) is identical to a provision in S. 1924 which we recommended. With the exception of the noted clause, that portion would not create a new benefit nor expand the outpatient care program nor would it involve any additional cost. However, the remaining provisions of section 101 including clause (iv) of subsection (a) would create new benefits, and for the reasons discussed in section 102, we strongly object to those portions of section 101.

Section 102

Paragraph (1) of this section would amend section 610 of title 38, to authorize the Administrator to furnish direct admission for nursing home care to certain veterans.

It probably would be necessary to admit a majority of the veterans covered by the bill to a VA hospital for medical evaluation to determine whether nursing home care is appropriate. This could be an expensive procedure and might defeat the very purpose for which the nursing home care program was initiated. Moreover, this amendment would apply to the enlarged group of eligibles by virtue of the amendments made by paragraphs (2) and (4) of this section. Thus, eligibility would extend not only to the service-connected war veteran but to any veteran for a nonservice-connected disability if he is unable to defray the expenses of such care and to dependents and survivors of certain veterans.

Under our current nursing home care authority (38 U.S.C. 620), which was added by Public Law 88–450, the Administrator is authorized to transfer any veteran patient in a VA hospital who has received maximum hospital benefits, and who requires protracted nursing home care, to a public or private institution for nursing home care at Government expense. The period of such care for which the Veterans' Administration can pay cannot exceed 6 months in connection with any one transfer, except in the case of the veteran whose hospitalization was primarily for a service-connected disability, or when the Administrator determines that a longer period is warranted. The law imposes a specific limitation that the cost to the Veterans' Administration of this nursing home care will not exceed 40 percent of the cost of care furnished in a VA general hospital.

One of the principal purposes of section 620 is to aid the veteran and his family in making the transition from the hospital to his place in the community. The legislative history also indicates an intent to "unfreeze" hospital beds occupied by long-term patients who have received maximum hospital benefits so as to make such beds available for care of acutely ill patients who could not otherwise be admitted. The proposed amendment would serve neither of these objectives of section 620.

Therefore, we cannot support the extension of nursing home care as proposed by this portion of section 102 of the bill.

It is not possible, because of the time limitations as well as many unknown factors, to estimate the cost of this portion of section 102. However, on a more modest proposal, to which we would also object, amending section 620 of title 38 in order to authorize direct admission to community nursing homes, at VA expense, of those veterans needing such care for a service-connected condition, we estimated the first year cost to be approximately $17.7 million. The cost of the subject proposal would exceed that amount many times.

Paragraph (2) would delete in section 610(a)(1)(B) "a veteran of any war or of service after January 31, 1955" and insert in lieu thereof "any veteran for a nonservice-connected disability".

Under current law, the Administrator may furnish hospital care to any veteran for a service-connected disability; or a veteran of any war, or of service after January 31, 1955, for a non-service-connected disability, if he is unable to defray the expenses of necessary hospital care; a veteran whose discharge or release from the active military, naval, or air service was for a disability incurred or aggravated in line of duty; a person who is in receipt of, or but for the receipt of retirement pay, would be entitled to disability compensation; and any veteran for a non-service-connected disability if the veteran is 65 years of age or older.

Historically, hospitalization of veterans for non-service-connected conditions has been limited to veterans of wartime service. Although Public Law 89–358 amended section 610(a)(1)(B) to include as eligible veterans those having service after January 31, 1955, providing no terminal date, it is not believed that there was any intent to depart from the aforesaid historical limitation. To the contrary, the failure to include a terminal date was, in our view, an effort by the Congress to extend wartime benefits during the so-called "cold war period" without attempting to define each incident giving rise to wartime for conditions which might occur. It left the way open for a future Congress, when conditions have changed, to place a termination date for that period of service for which these benefits would be afforded. Enactment of this provision extending eligibility for hospitalization of veterans for non-service-connected conditions to peacetime veterans would preclude the Congress from exercising its present option to fix such a terminal date.

For the foregoing reason, we cannot recommend that your Committee give favorable consideration to the enactment of this provision.

Based on the application of present average patient care cost to the estimated average daily patient census generated by this provision of the bill, the maximum estimated annual cost could be approximately $6.9 million.

Paragraph (3) would amend section 610(c) of title 38, which authorizes the Administrator, within the limits of VA facilities, to furnish medical services to correct or treat any non-service-connected disability of any veteran receiving hospital care in such facility, in addition, to treatment incident to the disability for which he is hospitalized under certain conditions, if the veteran is willing. Currently the Administrator must determine that the furnishing of such medical services (1) would be in the interest of veterans, (2) would not prolong hospitalization, and (3) would not interfere with the furnishing of medical services to other veterans.

The proposed amendment would delete the current conditions noted above and substitute the language "if the veteran requests such services and the Administrator finds such services to be reasonably necessary to protect the health of such veteran."

"Under the proposed amendment, the furnishing of additional medical services for any nonservice-connected condition for a hospitalized veteran on request would be conditioned on only one finding by the Administrator, that such services are reasonably necessary to protect the health of such veteran. That criteria would not permit any consideration as to whether the period of hospitalization would be extended; the effect on other veterans, possibly some with serious service-connected wounds needing attention; and the medical determination as to the benefit to the veteran himself. Moreover, it is doubtful that many veterans possess the medical knowledge as to whether they require medical services for other nonservice-connected disabilities they may have. Placing the duty on the veteran to make such a request is unreasonable and not in his best interest.

We feel that current law, giving the Administrator great flexibility in the furnishing of additional medical services to hospitalized veterans, provides the greatest benefit to all veterans and adequately meets the responsibility of the Government in caring for those who have borne our Nation's battles. Therefore, we oppose this amendment.

Because of the uncertainty as to the numbers of hospitalized veterans who would request additional medical services, the length of additional hospital bed occupancy such would require, and other unknown factors, it is not possible to estimate the cost of this proposed amendment.

Paragraph (4) would add a new subsection (d) to section 610 of title 38 to authorize care in Veterans Adiministration hospitals, including nursing home care, for the wife or child of a person who has a total and permanent service-connected disability, and for widows and children entitled to death compensation or dependency and indemnity compensation because of the death of a serviceman or veteran from a service-connected cause. Neither medical nor nursing home care in Veterans Administration facilities is authorized under existing law for dependents or survivors of veterans. These provisions which would have the effect of enlarging the class of VA beneficiaries to include nonveterans, present a major question of national policy.

There are now in operation a number of broad Government sponsored health care programs which provide services to millions of eligible men, women and children:

Medicare helps finance both hospitalization and physician outpatient care to over 20 million persons age 65 and over. Obviously, a large number of wives or widows of veterans are covered by this program.

Medicaid pays for the health services, including hospital costs, for an estimated 11 million men, women and children who meet applicable income eligibility standards.

The Military Medical Benefits program provides hospital and medical services to certain surviving dependents of persons dying in service, as well as dependents of those who die after retirement from service.

The President has a special concern for the problems of all Americans, including veterans and their dependents, who lack access to adequate medical care. In his Health Message of last February, he proposed a carefully designed program to:

Assure equal access of Americans to health care:

Balance supply of health care with demand: and

Organize medical care delivery on a more efficient basis: emphasizing preventive care and new forms of delivery, including health maintenance organizations.

The classes of beneficiaries which the bill proposes to add as wards of the VA hospital system would be assured access to medical care under the President's proposals. The proposed National Health Insurance Partnership and Family Health Insurance Program would, in combination with Social Security benefits, provide comprehensive health protection for both working and retired Americans, and for veterans' survivors, dependents, and peacetime veterans. This coverage would be superior to the care provided in this bill in two major respects:

It gives beneficiaries a choice of care in their communities; and

It provides preventive and maintenance health care.

The approach of this bill, in adding potentially 40 million adults and children to the patient care liability of the VA hospital system, threatens to so overload the capacity of VA's system as to render it unable to provide quality care for those beneficiaries for whom the system was originally established and who remain the prime obligation of the Government—the service—disabled veterans.

On the other hand, the President shares the Congress' concern that the unique capabilities of the VA medical system be used to help improve delivery of medical care to the American people. He has specifically directed the Administrator of Veterans Affairs to develop ways in which the VA medical system can be used to supplement local medical resources in scarcity areas.

With regard to peacetime veterans, historically, hospitalization of veterans for non-service-connected conditions has been limited to veterans of wartime service, and we cannot recommend a change in this philosophy.

For these reasons, we must oppose those provisions of the bill which would extend VA medical care to non-veterans and peacetime veterans.

We are unable to relate this legislative proposal to any compelling need. To the contrary, it would single out a limited group and provide for them an unwarranted additional source for receiving medical care at Government expense. We strongly oppose enactment of paragraph (4) of section 102, but would urge instead consideration of the President's health insurance proposals as contained in S. 1623.

The estimated cost of this provision of section 102 does not include the large construction costs which would be entailed but indicates the magnitude of operating costs if it were possible to expand VA-operated facilities to meet the potential demand.

Fiscal year 1972	$16,879,000
Fiscal year 1973	16,146,000
Fiscal year 1974	17,413,000
Fiscal year 1975	18,680.000
Fiscal year 1976	19,984,000
Total 1st 5-year cost	89,066,000

These costs are based upon the assumption that 20 per cent of the eligible wives, widows, and children who have other Federal eligibility such as medicare, medicaid, and military medicare, and that 68 per cent of those other eligibles without such entitlement would use VA facilities.

Section 103

Subsection (a) of this section would amend section 612(a) of title 38 to extend outpatient care to any veteran for any non-service-connected disability if he has a service-connected disability other than a non-compensable dental condition. It would also authorize outpatient care for the wife or child of a veteran who has a total and permanent service-connected disability and to widows and children entitled to death compensation or dependency and indemnity compensation. Such care could only be provided to the extent that it would not interfere with the care of veterans and could only be provided in a Veterans Administration or other Government facility.

It is estimated that the approximate annual cost of the proposed new subsection (a)(3) for the next five years, excluding cost of construction of any necessary additional facilities, would be as follows:

Fiscal year	Yearly cost	Wives, widows and children
1972	$101, 800, 000	$8, 700, 000
1973	108, 900, 000	9, 500, 000
1974	116, 500, 000	10, 300, 000
1975	124, 700, 000	11, 100, 000
1976	133, 400, 000	12, 000, 000
Total 1st 5-year cost	585, 300, 000	51, 600, 000

Expansion of our outpatient program, as proposed in subsection A would seriously undermine the Veterans Administration's ability to meet its primary obligation to provide high quality care to service disabled veterans and to selected others already eligible under existing law. The detailed discussion of paragraph (4) of section 102 above is equally applicable to this provision of section 103. For these reasons, we strongly oppose enactment of the provisions of this section as well.

We are not unsympathetic, however, to legislation which would expand our authority to give outpatient treatment to the present group of eligible veterans under certain circumstances.

Under current law and Veterans Administration regulations, outpatient treatment of veterans is generally restricted to service-connected disorders. Public Law 91–500 authorized outpatient care for any veteran who is in receipt of increased pension or additional compensation or allowance based on need of regular aid and attendance or by reason of being permanently housebound, or who, but for the receipt of retired pay, would be in receipt of such pension, compensation, or allowance.

Earlier, the provisions of Public Law 86–639 had extended outpatient treatment for a non-service-connected disability where such care is necessary in preparation for admission to a hospital or to complete treatment incident to hospital care.

The objectives of that legislation were reduction in the length of patient stay in the hospital, decrease in the cost per patient treated, and a partial check on the development of longer waiting lists as the veteran population ages. While, generally, such benefits have been realized during the period the law has been in force, certain restrictive provisions in the current law serve as an impediment to fuller achievement of these worthwhile goals. Medical services furnished must be limited to those necessary to prepare the patient for hospital care for which he has actually been scheduled.

There is a sizable number of applicants whose need for hospitalization cannot definitely be determined after routine examination. This group frequently requires extensive workup and recalls for consultation to confirm or rule out requirement for hospitalization. Realistically, such procedures often go beyond the need to determine hospital care and constitute treatment.

Section 102 of S. 1924 would amend subsection (f) of section 612 of title 38, to authorize the Administrator to furnish medical services for a non-service-connected disability where (1) such care is reasonably necessary in preparation for hospital admission or where such care is reasonably necessary for a veteran who is determined to need hospital care if not treated; (2) a veteran has been granted hospital care, and outpatient care is reasonably necessary to complete treatment; or (3) any veteran of any war who has a total disability permanent in nature from a service-connected disability.

In lieu of subsection (a) we recommend that the Committee incorporate language contained in S. 1924 to extend outpatient care where it will obviate the need for hospitalization.

New paragraph (4) to be contained in section 612(a) of title 38, as added by this section of the bill, provides that medical services may be furnished in VA facilities to any veteran for a non-service-connected disability (excluding first-aid or dispensary services for minor illnesses or injuries) which is determined to be in need of prompt medical attention under regulations prescribed by the Administrator.

As a technical matter, we believe this amendment should have been proposed to section 612(f). Nevertheless, we would again prefer the provision in section 102 of S. 1924.

The provisions of section 612(f)(1) if amended as suggested in S. 1924 will result in a more timely treatment of veterans on an outpatient basis whom the VA admitting physician has certified would otherwise require admission to a VA hospital. It is estimated that enactment of this provision would entail no additional cost to the VA hospital system, and may generate modest savings.

Subsection (b) of section 103 of the bill would amend section 612(f) of title 38 to clarify the authority of the Administrator to furnish medical services by fee or contract under certain circumstances. While we see no objection to clarifying the statutory language in this area, there would be no practical effect to such change. This subsection would also amend paragraph (3) of section 612 to authorize outpatient services where a veteran has a total disability permanent in nature from a service-connected disability. This would eliminate the current requirement that he be a war veteran.

Our comments on similar provisions in paragraph (2) of section 102 apply here, and we would object to the favorable consideration of this provision.

Section 104

This section would amend section 620 of title 38 to authorize the transfer to community nursing homes of any person who has been furnished care in any hospital of the Armed Forces and who upon discharge therefrom will become a veteran.

Section 620 of title 38 now authorizes the transfer of a veteran who has received maximum benefits from care in a Veterans' Administration hospital to a public or private institution for nursing home care at Federal expense, for a period generally not to exceed 6 months in connection with any one transfer. The period of nursing home care is not so limited where the hospitalization was primarily for a service-connected disability or when the Administrator determines that a longer period is warranted.

To be eligible for placement in a community nursing home, the veteran must have been admitted to a Veterans' Administration hospital and transferred with a maximum hospital benefits discharge. Only patients needing skilled nursing home care for convalescence, rehabilitation, or continued care for a protracted period of time are eligible for transfer to community nursing homes.

Currently, military personnel of the Department of Defense who are hospitalized by the military services and who are not to be returned to active duty are transferred by the Armed Services Medical Regulating Office to Veterans' Administration hospitals for necessary care. Such care is provided by the Veterans' Administration at the expense of the Armed Forces pending separation of such personnel from military service. An average of approximately 240 persons per month are so transferred.

Under current procedures, the Veterans' Administration has an opportunity to evaluate the patient medically and to determine, among other things, his need for nursing home care. The proposed procedure apparently contemplates a direct transfer from the military hospital to the contract nursing home but will still require a determination by the Administrator of Veterans' Affairs that such military patient has received maximum hospital benefits and that he will require a protracted period of nursing home care.

We believe that the proposed legislation is not only unnecessary but that it would unduly complicate present effective procedures for making the necessary administrative and professional determinations involved. While we do not know the number of persons who would be affected by the measure, it is our opinion that there would not be a material increase in our community nursing home care program.

For the foregoing reasons I recommend against favorable consideration of this legislative proposal by the committee.

Section 105

This section would amend section 626 of title 38 to authorize the Administrator to reimburse veterans in VA hospitals and domiciliaries for any loss of personal effects sustained by earthquake, or other natural disaster, in addition to the currently authorized provision relating to fire.

This provision would extend existing authority and it represents a piecemeal approach to the broader question of compensation by the Government for personal property losses resulting from natural disasters.

It is not possible to estimate the cost should this section be enacted.

TITLE II—AMENDMENTS TO CHAPTER 73 OF TITLE 38, UNITED STATES CODE, RELATING TO THE DEPARTMENT OF MEDICINE AND SURGERY

Section 201

This section would add a new subsection (c) to section 4101 of title 38, which would require the Administrator to provide for continuing study of and take appropriate action to implement the best possible methods of rendering health care services through such means as reassignment of duties between medical, allied professional, technical or other health personnel; establishing new positions of physicians' and dentists' assistants; establishing educational programs for academic credit; providing maximum mobility between health personnel positions, and through use of electronic, automated, computerized, or other mechanical devices.

This section appears to merely set forth an administrative policy for operation within the Department of Medicine and Surgery, with the exception of the granting of academic credit. Many of the concepts listed are in fact currently being carried out. It is not clear from the text of the provision what is intended by the use of the term "academic credit." If it is intended that the Department of Medicine and Surgery establish educational programs for general academic credit, that would appear to change the VA's role in education and training from our present concept as outlined in section 4101(b) of title 38.

We cannot recommend favorable consideration of this provision.

This section would also add a new subsection (d) to section 4101 of title 38, in order to attain comparability in the staff-to-patient ratio in VA hospitals with other public and private hospitals. To accomplish this objective, the Administrator, on a geographical or area basis, would be required to select a hospital having an optimum staff-to-patient ratio. The VA facility would then have to reach the staff-to-patient ratio of that index facilitiy within three years after the date of enactment of this subsection. The Administrator would be authorized to make a contract in order to secure the necessary information and statistical data for the selection of the index hospital. The Administrator would be required to submit a report to Congress each fiscal year describing the actions taken to implement these provisions and the extent to which these provisions have been implemented.

The philosophical objective of this provision is, of course, commendable as a basic concept. The Veterans Administration has always and will continue to seek and maintain staffing ratios designed to provide the maximum in high level care for veterans throughout the range of all facilities. Medical care conceptse are constantly changing. We believe that the provision for imposing a staffing ratio upon VA hospitals based upon index hospitals, as contained in Section 210(d), would have the effect of imposing inflexible and not necessarily valid standards upon management which would fail to take into consideration differences in mission, facilities, personnel, and patient care requirements. Such an imposed standard could prove expensive and inefficient in certain instances and a hindrance to appropriate treatment and care programs in others. We therefore do not favor this provision.

It is impossible to estimate with any accuracy the cost of this subsection. The actual cost, in any fiscal year, would depend upon the speed with which the staff was increased to meet the statutory deadline; the patient load during such fiscal year; and the changes in staffing patterns which would be made independently of this requirement in order to keep pace with the changes in medical specialties and patient care procedures.

Section 202

This section amends section 4103(a)(4) of title 38 to provide for the appointment by the Administrator, upon recommendation by the Chief Medical Director, of two additional Assistant Chief Medical Directors who are qualified in the administration of health services and who are not doctors of medicine, dental surgery, or dental medicine.

Under the provisions of Public Law 293, 79th Congress, enacted January 3, 1946, there were authorized not to exceed eight Assistant Chief Medical Directors in the Department of Medicine and Surgery. This number was reduced to five by Public Law 87–793 but increased to six in 1966 by Public Law 89–785. Hence, the net effect of the proposed amendment would be to restore the number of Assistant Chief Medical Directors to eight as previously provided, although for the first time, providing that two of them need not be physicians or dentists.

The expansion in the type of complex medical programs has concomitantly fostered an increased awareness of the necessity for sophisticated management techniques in implementing these programs. An organization as large and dispersed as the Department of Medicine and Surgery of the Veterans Administration, with an annual budget in excess of $2 billion, requires a wide range of specialized disciplines. To this end, the Chief Medical Director should have directly available to him individuals basically trained in management disciplines. These individuals will supplement the professional skills of the medical and dental Assistant Chief Medical Directors and will provide the Chief Medical Director with the full range of expertise needed to efficiently administer the agency's far-flung medical activities.

This section would also amend paragraph (7) of section 4103 in order to reflect the current title of the Director of Pharmacy Service and Director of Dietetic Service.

We would, therefore, recommend favorable consideration of this provision of the bill.

The gross cost resulting from enactment of this section would be approximately as follows:

1972	
1973	$75,000
1974	80,000
1975	85,000
1975	90,000
	95,000
Total 1st 5-year cost	425,000

These costs would be to some extent offset by savings in salary of classified personnel now performing related duties.

Section 203

This section would amend section 4104 of title 38 to authorize the Administrator to appoint additional personnel, including physicians, dentists and nurses, allied professional health care and scientific personnel for which he determines that a minimum of a baccalaureate degree (or its equivalent) in such a profession is required; physicians' and dentists' assistants; and health technicians. We cannot support this provision for reasons which are discussed in greater detail in section 206(b).

Section 204

This section would amend section 4105(a) of title 38, in order to authorize the Administrator to set the qualifications for physicians' assistants and dentists' assistants.

Subsection (b) of section 4105 of title 38 would also be amended to provide that, except as provided in section 4114 of title 38, no person may be appointed in the Department of Medicine and Surgery under section 4104 of this title unless he is a citizen of the United States.

This proposed amendment would in effect repeal current subsection (b) of section 4105 relating to the citizenship requirement for physicians, dentists, and nurses appointed under authority of sections 4103 or 4104 of title 38, and thereby eliminate the current citizenship requirement for persons appointed under section 4103. Accordingly, we cannot favor this proposed amendment for reasons which are discussed in greater detail in section 206(b).

Enactment of this amendment would not result in any additional cost to the Government.

Section 205

This section would amend section 4106 of title 38, concerning period of appointments and promotions, to add allied professional health care and scientific personnel, physicians' assistants, dentists' assistants, and health technician personnel, to subsections (a), (b), (c), and (e) of that section, and to provide that these personnel appointed pursuant to paragraph (2), (3) and (4) of section 4104 of this title shall be without regard to those provisions of title 5 governing appointments in the competitive service and the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates. Moreover, this section provides that the Administrator shall provide by regulation for benefits equivalent to those provided by sections 5333 through 5337 of title 5.

Comments which follow relative to section 206(b) of the bill are applicable to this section, as well as to sections 203 and 204. We cannot support this provision for reasons which are discussed in greater detail in section 206(b).

Section 206

(Beginning on page 12 of the bill)

Subsection (a) of this section would amend subsections (a) and (b) of section 4107 of title 38, in order to reflect the adjustment in rates of pay effected by Executive Order 11576, dated January 8, 1971, pursuant to authority vested by subchapter I of chapter 53 of title 5, as amended by the Federal Pay Comparability Act of 1970, and section 3(c) of that Act.

The per annum full-pay scale or ranges for positions in this amended schedule in excess of $36,000 are limited by section 5308 of title 5, as added by the Federal Pay Comparability Act of 1970, to the rate for level V of the Executive Schedule (as of the date of the Executive Order, $36,000).

Moreover, this section would amend the "section 4103 schedule" contained in section 4107(a) by providing that the salary range for the Director of Nursing Service would be changed from the equivalent of GS–15 to the equivalent of GS–17 and for the Director of Chaplain Service, the Director of Pharmacy Service, and the Director of Dietetic Service from the equivalent of GS–15 to the equivalent of GS–16. The VA in conjunction with the Civil Service Commission recently completed a study of these positions with a view to determine in particular the appropriateness of linkage in pay between the position of Director of Nursing Service and grade GS–15 under the General Schedule. It was the conclusion in this study that the position of Director of Nursing Service was clearly superior to GS–15 in level. The proposed adjustment in pay for the positions indicated is essential for alignment purposes and recognition of their individual responsibilities. The titles of Chief Pharmacist and Chief Dietitian are changed to that of Director of Pharmacy Service and Director of Dietetic Service, respectively, in order to parallel the existing titles for Director of Nursing Service and Director of Chaplain Service.

It is estimated that enactment of this portion of section 206 would result in an additional annual cost to the Government of approximately $10,500.

The joint study by the Veterans Administration and the Civil Service Commission also revealed that certain other nurse positions of those presently in the Assistant Director Grade, which equates in pay to grade GS–14 under the General Schedule, were superior to that grade relationship. Accordingly, the purpose of the new Director grade inserted in the "Nurse Schedule" by this amendment is necessary to recognize those positions. The pay range provided is equivalent to that of GS–15 under the General Schedule.

It is estimated that enactment of this part of section 206 would cost an additional $42,000 annually.

Subsection (b)(2) of section 4107 is amended to confine the prohibition against any person in the director grade serving in any other position than director of a hospital, domiciliary, center, or outpatient clinic (independent) to the "Physician and Dentist Schedule", in order to accomplish the purpose of the amendment creating a director grade in the "Nurse Schedule". We favor this provision.

Subsection (b) of this section would amend subsection (c) of section 4107 by redesignating subsection (c) as (e) and by inserting a new subsection (c) which would add two new schedules. These are the Allied Professional (AP) Schedule and the Health Technician (HT) Schedule.

The Allied Professional Schedule would provide a range of rates for grade 1 through 8, comparable to the range of rates for GS–7 through GS–16 of the General Schedule. Included in this schedule would be dietitians, pharmacists, therapists, medical technologists, research scientists and others requiring a baccalaureate degree or equivalent. Physicians' and dentists' assistants would be included at AP grade 2 or above.

The Health Technician Schedule would provide a range of rates for grades 1 through 9 comparable to the range or rates for GS–3 through GS–12 of the General Schedule. Included in this schedule would be technicians, licensed practical nurses, nursing assistants and other similar VA health care personnel employed in positions not requiring a baccalaureate degree or equivalent.

The effect of these provisions would be to remove approximately 52,000 VA General Schedule employees from competitive service appointments, classification, and pay. Of these, approximately 11,000 would be paid under the AP Schedule and approximately 41,000 would be paid under the HT Schedule.

The necessity of the close coordination between Federal medicine and the medical community in the developmental, training, and acceptance phases involved in the growth of new paramedical occupations, and the maintenance of a competitive pay position for such newly developed skills, is not a unique situation for the Veterans Administration alone. Under the terms of Public Law 91-216, Job Evaluation Policy Act of 1970, the Civil Service Commission is to develop a coordinated job evaluation and grading plan for Federal salaried occupations generally. The study group established pursuant to that law has as its primary function the coordination of classification and pay systems in the Federal service, including those positions contemplated by this subsection of section 206 of the bill. Therefore, we cannot recommend favorable consideration of this portion of section 206 by your Committee.

It is estimated that enactment of subsection (b) would cost approximately $1.3 million for the first year.

Subsection (c) would amend section 4107 adding new subsections (f), (g), and (h).

New subsection (f) authorizes the Administrator, upon a recommendation of the Chief Medical Director, to increase the annual salary of a physician who performs administrative duties by an amount not to exceed 20 per cent of his annual salary. The new subsection would not define the term "administrative duties" nor would it include other Department of Medicine and Surgery employees such as dentists in its provisions. The proposed new subsection would appear to inordinately recognize the administrative functions performed by physicians in relationship to their professional function in the care and treatment of veterans and would be difficult of equitable administration. We, therefore, cannot recommend its favorable consideration. Enactment of veterans and would be difficult of equitable administration. We, approximately:

Fiscal year 1972	$5,600,000
Fiscal year 1973	5,940,000
Fiscal year 1974	6,300,000
Fiscal year 1975	6,680,000
Fiscal year 1976	7,080,000
Total 1st 5-year cost	31,600,000

Subsection (g), as added to section 4107 of title 38, would authorize the Administrator, upon the recommendation of the Chief Medical Director, to establish higher maximum rates of pay for physicians, dentists, nurses, allied professional health care and scientific personnel, physicians' assistants, dentists' assistants, or health technician personnel, on a nation-wide, local, or other geographic area basis where required to meet competitive pay practices. However, such an increase may not exceed in corresponding amount the amount provided in the statutory range for that grade, nor exceed the rate established for Assistant Chief Medical Director.

The authority proposed to be vested in the Administrator to set special salary rates is the same as was vested in the President under section 5303 of title 5, United States Code, and delegated by the President under the provisions of part III of Executive Order 11073 to the Civil Service Commission. In addition to pay scales of the Department of Medicine and Surgery, that authority applies to the General Schedule and the Foreign Service schedules.

While in the past we have not felt the necessity for requesting the Commission to apply the special authority delegated by the President to establish special rates and rate ranges for positions covered by the Department of Medicine and Surgery salary schedules, we are assured that the Commission would work closely with us to establish higher maximum rates of pay on a nation-wide, local, or other geographic area basis where required to meet competitive pay practices.

Therefore, in view of the foregoing, we cannot recommend favorable consideration of the proposed new subsection 4107(e) which would be added by this section of the bill.

Initial estimates of the cost of section 4107(e) are about $13 million. However, such estimates are subject to variation and they would depend upon necessity for utilization of the authority.

Subsection (h), which would be added to section 4107 of title 38 by the bill, would authorize the Administrator to pay nurses compensated under the nurse schedule in section 4107(b)(1) of title 38, for duty performed in the evening, at night, on Saturday, Sunday, or on a holiday, or the sixth or seventh day of the workweek and for duty performed in excess of the regularly scheduled hours during a workday (other than a holiday).

Any nurse performing duty on an evening or night tour of duty would be paid additional compensation at a rate not exceeding 15 per cent of her hourly rate of pay; Saturday, 20 per cent; Sunday, 30 per cent; legal holiday, 100 per cent; 150 per cent, if in excess of her regular duty hours during any workday, other than a legal holiday; 150 per cent for duty on the sixth or seventh day of any workweek. A nurse performing duty on the sixth or seventh day of the workweek would not be entitled to additional compensation for Saturday, Sunday, or holiday duty. On request, compensatory time off from the nurse's regular scheduled duty in lieu of additional compensation for an equivalent amount of time could be granted, if appropriate.

The bill provides a formula for converting the per annum basic compensation rate into the hourly rate. Such hourly rate would be derived by dividing the annual rate of compensation by 2080, which represents the average number of working hours, per year, and is the same formula used in computing the hourly overtime and night rate of pay for Civil Service employees under title 5, United States Code, where the basic rate of pay of the employee is fixed on an annual basis. Moreover, it provides that "the additional compensation" provided by the bill would not be considered basic compensation for the purposes of lump sum leave payments, severence pay, compensation for work injury, retirement, life insurance, or other benefits relating to basic compensation.

Under current law, Veterans Administration nurses do not receive premium pay for those conditions of work which are generally regarded as more onerous to employees both within and without the

Federal Government. A study of hospital practices shows that non-Federal hospitals almost universally provide extra pay for nurses working on evening and night tours of duty. Also, by law, Federal employees under the General Schedule, Postal Field Service, and prevailing rate systems of pay are entitled to premium pay for such considerations as Sunday and overtime duty.

The Veterans Administration has found it very difficult to attract and retain qualified nurses for the evening and night tours of duty in many Veterans Administration hospitals. An impairment of our ability to provide adequate nursing care for our ill and disabled veteran-patients could result unless immediate action is taken to strengthen our position in this matter.

Developments in recent years with respect to the matter of nurses' pay in private, community and state hospitals throughout the country make it necessary for the Veterans Administration, which operates the largest single system of medical facilities in the world, to provide a rounded compensation plan for nurses, including customary provisions for premium pay, in order to remain competitive in attracting and retaining highly qualified nursing personnel.

On May 4, 1971, the Administrator of Veterans Affairs submitted a draft bill to the President of the Senate, which was subsequently introduced as S. 1924, 92nd Congress, and is currently pending before your Committee. Section 204 of that bill would provide for a differential pay system for nurses in our Department of Medicine and Surgery, which is predominantly similar to the provisions in other pay systems affecting Federal personnel. Therefore, we urge your Committee to give favorable consideration to S. 1924, which contains this and a number of other desirable provisions.

It is estimated that enactment of this portion of section 206 would result in cost of $32.0 million, while section 204 of S. 1924 would cost $16 million for the first fiscal year.

Section 206

(Beginning on page 20 of the bill)

This section amends section 4109 of title 38 to add a new subsection (b) granting retirement credit, not to exceed five years, to physicians and dentists, employed in the Department of Medicine and Surgery for a period of 20 years or more, for time devoted to pursuit of their professional degrees and for time devoted by them to a full-time internship in their profession. Such credit would be reduced by the period of Federal service performed by any such individual during the pursuit of his degree or performance of internship.

In reporting on bills having a similar objective to the Congress, we stated that we could not recommend favorable consideration of these bills and that the views of the Civil Service Commission should be sought. We remain of that view and reiterate that we cannot recommend favorable consideration to your Committee of this section of the bill. Section 206 proposes to credit for retirement purposes a period of time during which no Federal service was performed. To allow retirement benefits for such a period of time would be contrary to the "service" concept of the Civil Service Retirement System.

Enactment of section 206 would have no direct cost to the Veterans Administration. However, under the provisions of Public Law 91-93, the Government must pay the cost of all increases in the unfunded liability of the Civil Service Retirement and Disability Fund attributable to future legislation in equal annual installments. Based on a Civil Service Commission estimate, this would amount to $3.3 million annually, with the first installment due June 30, 1972. This would be a five year total of $16.5 million

Sections 207 and 208

These are technical amendments required because of other amendments to section 4104 of title 38.

Section 209

This section would amend section 4114 of title 38, relating to appointment of temporary full-time and part-time employees, and concerning residencies and internships, to add authority for the Administrator to appoint temporary full-time allied professional health care and scientific personnel, physicians' and dentists' assistants, and health technical personnel, for more than 90 days and to appoint such personnel on a part-time basis for more than one year under certain conditions.

This section would also amend section 4114(b) of title 38 to authorize the Administrator to enter into agreements for the central administration of intern and residency training and would allow him to expend appropriated funds for the purpose of paying to the central administrative body the costs involved for the periods during which the trainee serves with the Veterans Administration.

Under our present programs, there are three types of residents and interns: (1) those whose residency program is established and directed by a Veterans Administration hospital and who, although they may serve a portion of their residency in other hospitals, receive the entire amount of their stipends, fringe benefits and leave privileges under Veterans Administration regulations; (2) those whose residency program is established and directed by other than a Veterans Administration hospital but who serve a portion of their residency in a Veterans Administration hospital, receiving their stipends, fringe benefits, and leave privileges under Veterans Administration regulations only for the periods they are serving in a Veterans Administration hospital; and (3) those who residency program is established and directed jointly by a Veterans Administration hospital and one or more participating institutions, receiving their stipends, fringe benefits, and leave privileges under Veterans Administration regulations only for the periods they are serving in a Veterans Administration hospital. It is in the latter two types that administrative problems arise.

The movement of Veterans Administration residency and internship programs towards professional unification with the programs of medical school hospitals is ever increasing.

To accomplish intern and residency training within the concept now growing more prevalent, we feel that we must more and more resort to the integrated type of training wherein the trainee will serve a portion of his time in a Veterans Administration facility and may receive training in several other nongovernmental hospitals. This creates tremendous problems in that the pay, fringe benefits, and leave policies differ in the various institutions involved. Thus, when a trainee moves from one institution to another, it results in a great deal of confusion as to his entitlement to fringe benefits and leave. Moreover, it involves different rates of pay and there are routine delays, particularly while serving with the Veterans Administration, as would be the case in any Federal agency, in receiving his pay as a result of pay administration procedures. This situation can be remedied insofar as the nongovernmental hospitals are concerned and, in the past few years, we have been presented with more than 20 proposals for some type of accommodation which would permit us to participate in an intern or residency operation administered from a central point.

We feel that to do so would greatly enhance our ability to participate in this important area of medical personnel training. Moreover, it would be less costly in that our payments would be limited to those periods when the trainee is serving in our facility and the Veterans Administration is receiving his service.

We favor enactment of this provision.

Section 210

This section would clarify and extend the type of malpractice liability protection now provided medical personnel of the VA Department of Medicine and Surgery by the provisions of section 4116 of title 38, United States Code.

Section 4116 provides, in effect, that a suit against the United States under the Federal Tort Claims Act is the exclusive remedy of an individual seeking to recover for injuries arising while undergoing medical care treatment in a Veterans' Administration hospital. It was intended to immunize the Department of Medicine and Surgery medical personnel who are covered from personal liability arising out of their official VA duties. It has served its purpose well and has been an aid in the recruitment of much-needed medical personnel. Nevertheless, questions have arisen as to the scope of its coverage in certain situations where a suit against the Government cannot now be brought under the Federal Tort Claims Act (e.g., suits alleging assault and battery, libel and slander, false imprisonment, or relating to a work-incurred injury of a Federal employee).

While several recent decisions by the U.S. Court of Appeals for the Sixth and Ninth Circuits (i.e., *Van Houten* v. *Ralls*, 411 F. 2d 940 and *Vantrease* v. *United States*, 400 F. 2d 853) have added assurance that the type of protection provided by the so-called Drivers Liability Act (upon which the provisions of 38 USC 4116 were patterned) was intended to immunize the employees covered thereby from personal liability in all situations where they are sued as a result of their official duties (including when they are sued by a fellow employee for a work-related reasons), it is believed desirable to spell out authority in the law itself to insure such immunity.

In addition to providing clarifying language as to the intent of the law, in situations where a work-related injury to a fellow employee is involved, the amendment here proposed would provide Department of Medicine and Surgery medical personnel with a type of protection similar to that contained in the National Health Service Corps Act of 1970 (P.L. 91–623), applicable to Public Health Service Personnel. It would authorize the Administrator, to the extent he deems appropriate, to hold harmless or provide liability insurance for any person to which the immunity provisions of 38 USC 4116 are applicable, where such person might be held liable for damage to property, or personal injury or death, negligently caused while furnishing medical care and treatment (including the conduct of clinical studies or investigations) in the exercise of his duties in or for the Department of Medicine and Surgery, under circumstances where the injured party could not bring an action against the United States as provided by Sections 1346(b) or 2672 of title 28. For example, it would provide a means of protecting Department of Medicine and Surgery medical personnel who are assigned to a foreign country, or who are sued for assault and battery, false imprisonment, or libel and slander in connection with the performance of their assigned duties.

By filling a void which exists in areas where a suit against the Government under the Federal Tort Claims Act may now be precluded, this amendment would provide a means of insuring the immunity from personal liability arising out of the performance of official duties, which Congress intended to provide when the provisions of 38 USC 4116 were enacted. We would favor its enactment.

While enactment of this proposal may result in a slight increase in the Government's exposure to malpractice claims arising out of the activities of our medical personnel, any cost increase which may be involved would be more than offset by the improvement of morale which would result therefrom, and the added inducement in attempting to recruit shortage category health personnel.

Section 211

This section would amend section 4117 of title 38, to authorize the Administrator to enter into contracts to provide scarce medical specialist services at Veterans Administration facilities with medical schools, clinics, and any other group or individual capable of furnishing such services. This contracting authority would include, but not be limited to, services of physicians, dentists, nurses, technicians, and other medical support personnel.

This proposed amendment is intended merely to clarify current law which authorizes such contracting authority with medical schools and clinics. This contracting authority, insofar as clinics are concerned, has been interpreted by the Comptroller General of the United States (49 Comp. Gen. 871), to mean "any medical organization which is capable of contracting for and furnishing the services in question." Moreover, the Comptroller General was of the opinion that the term "medical specialist" may be construed "as including any professional or technician who performs specialist services related to providing medical care and attention."

Enactment of this section would clarify current statutory language whereby the Administrator could contract for scarce medical specialist services with medical schools, clinics, and any other group or individual capable of furnishing such services and where in an employer-employee relationship is established.

Enactment of this section would not result in any additional cost to the Government.

TITLE III—RELATING TO HOSPITAL AND DOMICILIARY FACILITIES; LEASING AUTHORITY OF THE ADMINISTRATOR; SPECIALIZED MEDICAL RESOURCES; USE OF EXCESS HOSPITAL BEDS; AND TELEPHONE SERVICE FOR CERTAIN MEDICAL OFFICERS

Section 301

Subsection (a) of this section would amend section 5001(a) of title 38, relating to the authority of the Administrator, subject to the approval of the President, to provide hospital, domiciliary, and other facilities, in order to require the Administrator to maintain an average daily patient census in beds of at least 84,500 patients.

During fiscal year 1972 our average daily patient census of 79,000 patients is not expected to result in a reduction in patient care. Given the improved staffing we have asked for and the increased ability to use other more appropriate treatment modalities (especially ambulatory care), more patients will be treated in VA hospitals than ever before in a twelve-month period. And, considering all VA facilities, more patients will be treated on a daily average than ever before. Ambulatory care visits will be up by nearly one-half million. Thus, we plan to take care of more veterans in 1972 than we did in 1971 by increasing our patient turnover rate and outpatient visits thereby increasing the availability of health care to the veteran population. Enactment of our proposal liberalizing outpatient authority contained in S. 1924, would add measurably to our ability. To provide in law for *any* specific minimum average daily patient census will only make for both bad medical practice and wasteful administrative practice. If hospital management must, on an average daily basis, meet some present census that is higher than necessary, we tend to destroy a desirable incentive to move patients through our health care system in an orderly and effective manner, and, wherever possible, to return them to their homes and jobs as quickly as is medically sound and possible.

We must not take away the physician's prerogative to treat each patient in a manner best suited to his needs. It would be very unfair to the patient and his family, unfair to the taxpayers, and very definitely contrary to the trend in American medicine today—a trend toward ever more effective treatment modalities, a trend which President Nixon's health care message of February 18 supports and encourages. It is also a trend in which the VA medical care system has taken a leading role, especially in the ten years since our appropriations measures ceased to include a specific census figure.

A return to such legislation would cause a reversal in our constantly improving length-of-stay experience; it would retard our efforts to improve and expand other treatment modalities, especially so in the case of ambulatory care and nursing-home care; our hospital beds would become increasingly filled with the chronically ill who can best be cared for in another manner either within our system or under VA auspices. The tragic result would be a lower quality of care for all patients.

Therefore, we strongly object to the requirement contained in this portion of section 301.

This subsection of section 301 would also amend paragraph (3) of section 5001(a) to require the Administrator to establish and operate not less than 6,000 nursing home care beds in the fiscal year ending June 30, 1972, 8,000 in the fiscal year ending June 30, 1973, and 10,000 in the fiscal year ending June 30, 1974, and each fiscal year thereafter.

Public Law 88–450 authorized the Veterans Administration to operate within its own medical system not less than 4,000 nursing care beds. At the same time it provided in section 620 of title 38 authority for the Veterans Administration to transfer a hospitalized veteran patient who has reached the nursing home care stage to a public or private institution for nursing care at Federal expense for a period generally not to exceed six months. Both of these provisions have had the desired effect of removing from active hospital beds operated by the Veterans Administration those patients who no longer need hospital care but truly need nursing care. It also had an effect on reducing the hospital load throughout the entire Veterans Administration medical system. The program, both that administered by the Veterans Administration, as well as that operated in community nursing homes under VA auspices, has worked extremely well. The VA is currently operating 6,000 nursing care beds in its facilities.

We feel that curent authority is sufficient and therefore, would not favor the enactment of this portion of section 301.

Also, the bill would amend paragraph (3) of section 5001(a) to provide that the Administrator shall convert to nursing beds any hospital beds which are not being adequately utilized for hospitalization purposes and which are located in structurally sound, functionally adequate, and fire, earthquake and other natural disaster resistant buildings, if the need for nursing beds cannot be satisfactorily met otherwise. When so converted, these beds would count against the nursing beds requirement.

We do not favor this portion of the bill since determination in this area should be based upon present need, staffing, and future requirements rather than on a mandatory requirement such as proposed.

Subsection (b) of this section would amend section 5001(b) in order to provide that hospitals, domiciliaries and other medical facilities provided by the Administrator shall be of fireproof and earthquake and other natural disaster resistant construction in accordance with standards which the Administrator shall prescribe on a State or regional basis. When an existing plant is purchased, it would have to be remodeled to comply with the established standards. The provision requires the appointmement by the Administrator of an Advisory Committee on Structural Safety of Veterans Administration Facilities to advise him on all matters provided for in this section.

As the sponsor indicated at the time of introduction, this proposal was engendered by the loss of the VA Hospital, San Fernando, in the earthquake of February 9, 1971. Basically, it would place in the statute plans and procedures which we have already implemented and we therefore believe that legislation on this topic is unnecessary. We believe the Committee would be interested in some of the details of the action now being taken and I am enclosing with the report a general statement as to what has been done to date.

Section 302

This section would amend section 5012(a) of title 38, which permits the Administrator to lease lands or buildings under his control for terms not exceeding three years, to exempt such leases from (1) the provisions of section 5 of title 41 requiring advertising where the lease exceeds $500; and (2) from the provisions of section 303b of title 40 which bars lease provisions calling for alteration, repair, or improvement of such leased property as part of the consideration for the rental to be paid. Under the change, the lessee would be permitted to maintain, protect, or restore property where such property is leased to public or nonprofit organizations.

The Veterans Administration only out-leases property when it is temporarily excess to its needs. We do not lease for strictly commercial purposes, but only for civic, health, educational or local government use. Thus, advertising in these cases serves no useful purpose but does involve time and expense that is considered unnecessary.

When the Veterans Administration does out-lease property it is most usually to satisfy a particular civic or local community need and is generally to a public or non-profit organization. In many instances there are benefits, either directly or indirectly, accuring to the Government. Also, there is to be considered the community relations benefits that are derived. In negotiating the rental value we set a rate that will serve to recapture the value of all services provided by the Government. However, in some instances we could be relieved of certain expenses for materials and personnel if we could require the lessee to provide for maintenance and protection of the property leased. We favor this provision.

It is estimated that the enactment of this section would not involve any additional cost to the Government, but could result in some savings.

Section 303

Subsection (a)(1) of this section would amend section 5053(a) of title 38, by deleting immediately after the parenthesis the words "or medical schools" and inserting immediately after the close parenthesis the words "or medical schools or clinics". Current law (38 USC 5053) requires that the medical school have hospital facilities before any sharing agreement can be made between the medical school and the Veterans Administration.

The amendment proposed here would cure this defect and authorize the Administrator to enter into a contract or agreement with a medical school, whether or not it has a hospital, and with clinics, for the mutual use, or exchange of use of specialized medical resources. We favor this provision.

Section 304

This section would amend chapter 81 of title 38, United States Code, by adding a new section 5053A authorizing the Veterans Administration hospitals to furnish, under contract, hospital beds, with supporting services, to other hospitals or other installations having hospital facilities or medical schools or clinics in the medical community, when not needed for the care and treatment of veterans. The authority which would thus be granted would be an extension of our present sharing authority (38 USC 5053).

In our letter to the Congress on April 23, 1965, requesting enactment of our current sharing authority, we stated:

> While current law permits the use of our facilities by nonveterans in emergencies for humanitarian reasons, we are unable to permit the use of such facilities and equipment, as well as expertise of our staff, for nonemergent situations even if there are no other similar facilities available. This situation exists even though these scarce medical facilities are not always utilized to

> the maximum and could be available to the community, without detriment to the care and treatment of veteran beneficiaries, during periods when our immediate needs do not require maximum utilization.

Although the language of the present authority would appear to be sufficiently broad to encompass the sharing of beds surplus to our needs, as contemplated by the subject bill, this question was resolved by the legislative history of the enactment of the sharing authority. In Senate Report No. 1727, to accompany H.R. 11631, 89th Congress (p. 12), the committee stated:

> Some apprehension has been expressed that the language of this legislation might be construed to authorize the use of Veterans Administration medical care beds by nonveteran patients of private or other Federal facilities on the basis of a shortage of such beds in the medical community. Specifically, there was some concern that the language in section 5052(c) which reads "For the purpose of this section the term "specialized medical resources" means medical resources (whether equipment, space or personnel) which because of cost, limited availability, or unusual nature, are either unique in the medical community or are subject to effective utilization only through mutual use," would authorize such a construction. Such a broad interpretation was in no way intended by the Veterans Administration in recommending this legislation, nor by this committee in reporting it, and, therefore, would not be permissible. Since the major purpose of this legislation is to strengthen and improve VA hospitals, the committee emphasizes that no provision shall be construed to authorize any reduction in medical services available to veterans.

In view of that language, we have held that we do not have authority to contract with hospitals, medical schools or other medical installations having hospital facilities for the use of our hospital beds, even though such beds are not needed for the care and treatment of veterans.

In a hospital system as large as the Veterans Administration hospital system, some excess beds will exist which are either staffed or which could readily be staffed. Our experience has shown that in a number of such instances these facilities could have been utilized for the benefit of the community without any interference with our primary mission of meeting the medical care and treatment needs of our veteran beneficiaries. Two examples of such a situation, which occurred during the past year, may be mentioned.

First, a medical school with hospital facilities with which one of our hospitals was affiliated needed some additional bed capacity. There were unused beds available in the Veterans Administration hospital, but they were not staffed. Those beds could have been activated with the assistance of the staff of the medical school and would thus not only have assisted the community but, at the same time, enhanced Veterans Administration health care by attracting high caliber personnel interested in the extended training opportunities which would have existed.

The second case involved an affiliated medical school which did not have a hospital and depended on community hospitals for the clinical treatment of medical school patients, and we had beds excessive to our use and, moreover, could have provided certain specialized medical resources had it been permissible to furnish hospital beds for the use of medical school patients. In such a case it would be beneficial to our hospital care program, to the medical school, and to the community if we were in a position to execute an agreement with the medical school as would be authorized by this section.

The type of contract proposed would be subject to the same requirement for reimbursement of full costs to which other types of sharing contracts are now subject. Under those circumstances, increased costs would not be involved and enactment of this section could result in some savings being realized. We favor this provision.

Section 305

This section amends section 234 of title 38 to permit the installation of official telephone service in the private residences, apartments, or quarters of non-medical Veterans Administration hospital, independent clinic, domiciliary, and center directors.

Present law permits such official telephones only for directors who are physicians. This direct service has proven very valuable in (a) local within hospital emergencies, including such instances as berserk patients and employees, shootings, an employee held as a hostage, and the sudden death of a key employee while on duty after hours; (b) local community emergencies such as Hurricane Camille, tornadoes, and train collisions with multiple victims; and (c) national and area civil defense programs where the support, participation, and coordination by each Veterans Administration hospital director is required on a planned basis. This has permitted direct communication with these key officials without having to compete with the normal family telephone. More well-trained non-medical administrators are becoming available to us as hospital, center, clinic and domiciliary directors and we believe that these non-medical directors have as great a need for rapid telephone service in the case of these within-facility, local, or civil defense emergencies as the other directors.

It is estimated that such a proposal would cost approximately $3,000 annually. We favor this provision.

EXHIBIT "A"

ACTIONS TAKEN BY VA SINCE THE SAN FERNANDO EARTHQUAKE

We have appointed an Earthquake and Wind Forces Committee to conduct a study of present national and local codes, and based on these, to develop new criteria, standards and procedures for the design of new VA hospitals and for strengthening existing VA hospitals as necessary to resist forces of natural disasters. The Committee members are:

Dr. Bruce A. Bolt, Professor of Seismology, University of California;

Mr. Roy G. Johnston, Consulting Engineer, Los Angeles, California;

Dr. Mete A. Sozen, Professor of Civil Engineering, University of Illinois; and

Mr. James Lefter, Director, Civil Engineering Service, Veterans Administration.

The Committee has inspected several VA hospitals in California and in New York to become familiar with our facilities and has prepared a procedure for the evaluation of our existing facilities in California in terms of earthquake hazards. The Committee met here in Washington July 12 and 13 to report on its accomplishments to date. One of the Committee's recommendations is the establishment of a procedure similar to that used by the Atomic Commission, to determine the seismic risk at a given hospital site. This procedure will be more realistic than relying on a Seismic Risk Map such as the one in the current Uniform Building Code. We have asked the Geological Survey and the National Ocean Survey to assist us in implementing this new procedure.

In its preparation of design criteria and procedures, the Committee will gather and analyze presently existing information rather than undertake or inaugurate new research projects. It will engage experts in various fields such as geology, soil mechanics, structural dynamics, and meterology for special reports. At this time, its major effort is in the following areas:

(a) Procedures to evaluate sites;

(b) Modification of the Earthquake Regulations of the Uniform Building Code, the most widely accepted such code, for the design of new VA structures;

(c) Criteria for the evaluation of existing facilities; and

(d) Procedures for the inspection of mechanical and electrical equipment to ensure that the hospitals will be operable after an earthquake.

We have employed local architect-engineer firms to inspect the buildings at our hospitals in Livermore, Palo Alto (Menlo Park), San Francisco, and the Los Angeles Center. We anticipate that these firms will complete their evaluations of the stations in about two or three months. At that time, based upon their observations and studies, the firms will develop preliminary designs and cost estimates for strengthening the critical buildings as necessary and eliminating hazards. These studies will form the basis for economic analyses and for judgements as to the advisability of improving the buildings for continued use. We are also in the process of appointing local architect-engineer firms to evaluate our hospital buildings at Salt Lake City, American Lake, Walla Walla, Vancouver, Portland, Roseburg and White City; with the objective of having these studies completed as soon as possible. It is believed that these eleven hospitals represent our most serious earthquake risks in terms of location and construction.

As indicated above, evaluation surveys by local architect-engineers are now underway at four hospitals in California, although no results have yet been reported. However, when the Earthquake and Wind Forces Committee visited our Livermore Hospital in May, it reported that three Ambulatory Cottages and the Recreation Building were of a type of construction that is susceptible to collapse in the event of an earthquake. The buildings have been evacuated.

Our Engineers are reviewing and classifying our hospitals in other sections of the country in terms of construction and occupancy preparatory to selection of architect engineers who will conduct the inspections and evaluations. It should be noted that until recently few structures except on the West Coast were designed to resist seismic forces, and even today such structures represent a very small proportion of the total number of structures in the East. Although there have been major earthquakes in areas such as Missouri and upper New York State, major earthquakes in these regions are rare. The Atomic Energy Commission estimates of ground shaking in these regions are one-half or less than those in more active seismic areas such as California. Consequently, we believe it may not be necessary to evaluate our hospitals in these eastern regions on the same basis as those in California. Our Earthquake and Wind Forces Committee is trying to establish criteria that will provide the same level of safety in terms of earthquake risk in all earthquake prone areas. We have found no precedents for a nationwide program comparable to the one that we have undertaken. There have been several local programs in California and we have drawn upon experiences of local building officials and the State of California Office of Architecture and Construction.

We are currently in the process of reassessing our long-range bed requirements for the Southern California area taking into account the loss of the San Fernando beds with the view toward replacing these beds in locations that will best serve the needs of the veteran population in that area.

We have taken the following actions as a result of our experience in the San Fernando hospital disaster:

(1) Local architect-engineers will evaluate existing VA structures in seismic areas.

(2) We are establishing procedures to evaluate future sites for seismic and geologic hazards.

(3) We are developing codes and standards for VA design against wind and seismic forces.

(4) We have reexamined our communications systems at all hospitals to determine their adequacy in the event of emergency. A program has been developed to expand the systems where necessary so that each hospital has mobile equipment for intra-hospital communication in the event of an emergency and also portable equipment that will permit communication with other VA hospitals and local community resources.

(5) Disaster plans at each hospital are continually reviewed and revised to assure that they are workable and current.

(6) We have met with the Office of Emergency Preparedness and advised them of our plans. We will keep them informed on our progress and accomplishments.

We have divided the evaluation of our existing hospitals into two phases. One, investigation of hazards, and two, preliminary design and cost estimates for strengthening as necessary and the correction of hazards. We expect to complete both phases of investigation for the most hazardous structures within the next six months. We will review the reports and develop priorities in terms of occupancy, location and construction. Funds for repairs will then be requested in the Construction of Hospital and Domiciliary Facilities appropriation. In the event we find patient and/or employee-occupied buildings below an acceptable risk level, it will be necessary to take steps to correct such deficiencies if this is economically feasible or to discontinue use of such buildings and compensate for the loss of such facilities in our overall long range program to replace obsolete hospitals.

Immediately after the San Fernando disaster, we established an Earthquake Damage and Investigations Fund within our Construction of Hospital and Domiciliary Facilities appropriation allocating unobligated balances of funds available to the extent that they are required. Last Tuesday the Senate, in passing our 1972 appropriation bills added $3 million to the Construction of Hospital and Domiciliary Facilities appropriation to provide for these costs and the Fayetteville, North Carolina, tornado damage that occurred last February 22. To datae, funds in the total amount of $1,638,500 have been allocated as follows:

	Damage	Surveys	Total
Livermore, Calif		$30, 000	$30, 000
Long Beach, Calif	$7, 700		7, 700
Los Angeles, Calif. (domiciliary)	61, 000		61, 000
Los Angeles, Calif. (Wadsworth)	100, 000		100, 000
Los Angeles, Calif. (Brentwood, Domiciliary & Wadsworth)		80, 000	80, 000
Palo Alto, Calif. (Menlo Park)		20, 000	20, 000
San Fernando, Calif	331, 000		331, 000
San Francisco, Calif		30, 000	30, 000
Sepulveda, Calif	638, 800		638, 800
Other VA stations to be surveyed		340, 000	340, 000
Total earthquake costs	1, 138, 500	500, 000	1, 638, 500
Fayetteville tornado damage costs	404, 000		404, 000

As indicated above, we are not yet in a position to estimate construction costs that may be required to strengthen existing facilities. However, we are hopeful that our studies of the most critical hospitals will advance rapidly enough so that we may be in a position to give consideration to requirements for some of these hospitals in our Fiscal Year 1973 budget which will be submitted to the Congress next January.

92d CONGRESS
1st Session

S. 2355

IN THE SENATE OF THE UNITED STATES

July 27 (legislative day, July 26), 1971

Mr. Cranston introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

A BILL

To amend title 38, United States Code, so as to afford advanced residency-type training to medical personnel of the Veterans' Administration and other Federal Departments and Agencies at Regional Medical Centers established at Veterans Administration hospitals throughout the United States.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Veterans' Administration Continuing Medical Education Act".

Sec. 2. Chapter 73 of title 38, United States Code, is amended by adding at the end thereof the following new subchapter:

II

"SUBCHAPTER II—REGIONAL MEDICAL EDUCATION CENTERS

"§ 4121. Designation of Regional Medical Education Centers

"(a) In carrying out his functions under section 4101 of this title with regard to the training of health manpower, the Administrator shall designate as Regional Medical Education Centers such Veterans' Administration hospitals as he determines appropriate to carry out the provisions of this subchapter, but in no event shall he designate less than four. The Administrator shall, to the extent feasible, designate such Regional Medical Education Centers in geographically dispersed areas of the United States.

"(b) Each Regional Medical Education Center designated under subsection (a) of this section shall provide continuing medical and related education programs for medical and health personnel of the Veterans' Administration and, to the extent that the Administrator determines such facilities are available, for others on a reimbursable basis. Each such center shall provide intensive, advanced training of the very highest calibre. Such training shall be in residence and shall include, but shall not be limited to (1) the teaching of newly developed medical skills and the use of newly developed medical technologies and equipment, (2) advanced clinical instruction, (3) the opportunity for conducting clinical investigations, and (4) routine verification of basic medical skills and, where determined necessary, remediation of any deficiency in such skills.

"§ 4122. Supervision and staffing of centers

"(a) Regional Medical Education Centers shall be operated under the direct supervision of the Chief Medical Director through the Assistant Chief Medical Director for Research and Education. Each such center shall be staffed with personnel qualified to provide the highest quality instruction and training in various medical care disciplines.

"(b) As a means of providing appropriate recognition to individuals in the career service of the Department of Medicine and Surgery who possess outstanding qualifications in a particular medical discipline, the Chief Medical Director shall from time to time and for such period as he deems appropriate assign such individuals to serve as visiting instructors at Regional Medical Education Centers.

"(c) Whenever he deems it necessary for the effective conduct of the program provided for under this subchapter, the Chief Medical Director is authorized to contract for the services of highly qualified medical personnel from outside the Veterans' Administration to serve as instructors at such centers.

"§ 4123. Personnel eligible for training

"(a) The Chief Medical Director shall determine the manner in which personnel are to be selected for training in the Regional Medical Education Centers. Preference shall be given to career personnel of the Department of Medicine and Surgery. Medical care personnel from other Federal departments and agencies shall be eligible for in residence training in the Regional Medical Education Centers, but the Veterans' Administration shall be reimbursed by such departments and agencies for providing such training. Medical care personnel from outside the Federal Government may be afforded training under this subchapter, to the extent that facilities are available, on a reimbursable basis.

"§ 4124. Consultation

"In carrying out the provisions of this subchapter at any hospital designated as a Regional Medical Center under section 4112 (a) of this title, the Chief Medical Director shall consult with and seek the advice of the advisory group established for such hospital under section 4112 of this title."

SEC. 3. (a) The table of sections at the beginning of chapter 73 of title 38, United States Code, is amended by inserting at the beginning of such table the following:

"SUBCHAPTER I—ORGANIZATION; GENERAL"

(b) Such table of sections is further amended by adding at the end thereof the following:

"SUBCHAPTER II—REGIONAL MEDICAL EDUCATION CENTERS

"4121. Designation of Regional Medical Education Centers.
"4122. Supervision and staffing of centers.
"4123. Personnel eligible for training.
"4124. Consultation.

"SUBCHAPTER I—ORGANIZATION; GENERAL".

[From the Congressional Record—Senate—Tuesday, July 27, 1971]

S. 2355 VETERANS' ADMINISTRATION CONTINUING MEDICAL EDUCATION ACT

Mr. CRANSTON. Mr. President, to maintain a high quality of medical care in Veterans' Administration hospitals and other medical facilities, there must be a continuing exchange of information and medical techniques between the staff of the VA facilities and the major medical centers and community hospitals of the Nation. S. 2355 which I introduce today as the proposed "Veterans' Administration Continuing Medical Education Act" will provide a means whereby this exchange can be assured and expanded.

S. 2355 authorizes the Administrator of Veterans' Affairs to designate at least four Veterans' Administration hospitals as "Regional Medical Education Centers." These centers must be geographically dispersed throughout the Nation and would provide continuing education programs and related educational pursuits to professional and other health staff of the Veterans' Administration facilities in the region. Where staff and facilities are available, these educational programs could also be offered on a reimbursable basis to medical personnel of other Federal departments and agencies and to medical personnel from the general community.

Training at these centers would thus provide an opportunity for VA staff personnel, as well as staff of other Federal agencies, and members of the surrounding medical community to participate in programs keeping them abreast of newly developed medical skills and knowledge, as well as in the use of newly developed medical technologies and equipment. To assure that each center would provide the latest and finest quality training, the chief medical director of the Veterans' Administration would be authorized to assign those individuals in the VA career service who possess outstanding qualifications in a particular medical discipline to serve as visiting instructors at the newly established regional medical education centers. He would also be authorized to contract for the services of eminently qualified medical personnel from outside the Veterans' Administration to serve as instructors at such centers, whenever he deemed it necessary for the success of the program.

A great benefit offered by these regional medical education centers will be that of providing continuing education in a clinical, residency-type setting, where the participant can obtain and apply his knowledge easily and immediately, increasing his ability to comprehend and utilize new skills, rather than, as in so many instances of continuing education programs, passively attending lectures and reviewing reading materials, and then trying to relate new knowledge to a patient at some unforeseeable time in the future. Training at a regional medical education center could thus be likened to an advanced residency program, where the participant could refresh his skills, utilizing the latest equipment, and learn new methods, procedures and techniques in providing health care.

Participants would also be exposed to the roles that are developing—many being developed on a pilot basis at VA hospitals—for new types of health personnel, for example, the technician specializing in orthopedics, or anesthesiology, or treatment of cardiovascular conditions, the physicians' or dentists' assistant, or the nurse practitioner, and learn to work with them in a manner which would achieve the greatest coordinated utilization of the skills of all levels of the medical care team.

A corollary benefit of regional medical education centers would be the recognition assignment to such centers can give to outstanding staff members, beyond the intellectual challenge and satisfaction involved.

This bill's intent is not to diminish the already excellent continuing education programs provided in many Veterans' Administration hospitals, but rather to build upon those programs that presently exist and to increase their availability to medical personnel both within the VA and in the surrounding medical community.

In the current fiscal year, almost 17,000 members of the Veterans' Administration medical staff will participate in continuing education programs, offered either within the VA or at medical centers. Of these, almost 8,000 received education in VA facilities. These programs are for the most part short term, highly specialized courses lasting for a week or less. The VA also sponsors an extensive lecture program, planning to present some 6,700 lectures at VA hospitals in fiscal year 1972. Participation in these programs is intensely sought, and in many cases, staff members are turned away because of the inability of the facility to provide the training to all those who seek it.

A program which has been highly successful is the so-called "Type A" postgraduate in-service training program which is a highly specialized longer term—2 to 5 weeks—intensive program geared to the educational needs of an individual, and usually oriented toward specialists. These programs are offered regionally by those Veterans' Administration facilities which are affiliated with medical schools and which can offer the highest quality environment for such training. Participants are staff members of unaffiliated VA hospitals in the region.

Last year some 25 of these highly specialized refresher training programs were offered; this year the number will be doubled to 50.

S. 2355. "The Veterans' Administration Continuing Medical Education Act," will enable the VA to expand and increase such programs, and, along with the benefits which accrue to the veteran from improved treatment capability, will provide a more attractive career for members of the health and allied health professions in the career service of the Veterans' Administration. In addition, the bill will make such programs more available to members of the medical community at large.

In this way this bill complements S. 2354, the proposed "Veterans Health Care Reform Act of 1971," which I am also introducing today and which includes provisions substantially revising the department of medicine and surgery personnel benefits and system.

Mr. President, I ask unanimous consent that there be set forth in the RECORD at the end of my remarks a paper prepared by Dr. E. Grey Dimond, Provost for the Health Sciences, University of Missouri at Kansas City, in which he outlines the benefits that can accrue from continuing education programs based at Veterans' Administration medical facilities. Although Dr. Dimond's proposal goes beyond that included in S. 2355, I feel much of what he suggests is realistically achievable and have incorporated those portions in the "Veterans Administration Continuing Medical Education Act."

A NATIONAL GRADUATE MEDICAL CENTER

(By E. Grey Dimond, M.D.)

Continuing or postgraduate medical education is a well-endorsed need. Voluntary health agencies (e.g. the American Heart Association), professional societies (e.g. American College of Physicians), and medical schools (e.g. the University of Kansas School of Medicine) are involved effectively in this area. This listing is incomplete, and the American Medical Association, state medical societies, medical journals, books, and films have, of course, essential roles in the continuing education of physicians.

The influence of the Regional Medical Program in this field, will be major. As each Regional Medical Program develops, not only will efforts similar to those at Kansas result, but also the teaching arena will extend out into the community hospital. The excellent short, one- to four-day courses which are the present "style" for continuing medical education will be augmented by steady, persistent educational activities at the physician's local hospital.

These efforts, and others not mentioned, even if all operative, still leave a specific deficiency.

There remains the major self-renewal challenge which no existing mechanisms solve. Specifically, how can a busy physician obtain in-depth training, at the bedside, and learn entire new skills? The continuing education programs already existing offer him one- to five-day refresher experiences which but serve to maintain, at least in part, a current information base. Almost all continuing education is a passive, lecture-style experience. Very few programs permit active engagement by the teacher and the learner in real or live patient-care settings.

Lengthy periods of time, wearing white hospital clothes, fully carrying out the duties of a resident physician would seem the only means of learning new skills and also, after a period of several years in practice, would seem to be the only way of rechecking one's basic medical knowledge, correcting deficiencies, altering habits, and, in truth, gaining self-renewal.

There is no graduate center in the United States which is expressly operated as a health facility for the physician to obtain such in-depth training. At a few medical school hospitals, occasional residencies are filled by returned physicians. However, not only are these physicians few, but the competition is keen, with priorities given to the young men coming along the straight path from medical school.

My proposal as an antidote is the designation of one or more Veterans Administration hospitals as national graduate medical centers. These centers should be nationally and internationally publicized as institutions conceived by the VA in which the highest possible standards of medical care will be used as the basis for graduate clinical instruction and clinical investigation. At these centers the staff would be augmented by visiting clinicians from the best US institutions. These visiting teachers would be present on a rotating, short-term basis of a few days or a few weeks. In addition, throughout the VA, the best career physicians would be invited for similar short teaching experiences. The majority of the residency positions would be designated sabbatical-leave residences, and, through the nation's journals, the practicing physician would be alerted to the fact that here is a center especially prepared for his need and offering funded training positions of from 1 to 12 months.

The educational and patient-care program of this facility would be placed under the direct supervision of the medical director of the VA, and he in turn would appoint an advisory committee which would regulate the use of this significant facility. A basic permanent staff of career VA physicians, proved as teachers, would be assigned to the center.

In addition to the permanent staff, outstanding career VA physicians would also be invited to the center and would receive recognition and honor as visiting clinicians. This obvious stimulus to the career physician could serve as an important excitant in his professional life.

A present fault, I suggest of the Veterans' Administration as a career for the physician is the relative inability to maintain wide recognition and personal credit for his skill as a clinician. In private practice such recognition comes from the size of practice, size of income, social recognition in the community, and high officership in professional societies. These elusive but important kudos of life are denied, relatively to the career VA physician. A widely publicized program, recognizing one's abilities as a clinician-teacher and one's invitation as a visiting clinician to the National Graduate Medical Center could be an effective antidote.

In a broader sense, the VA medical department has also suffered from anonymity. The very success of the program which has placed the VA hospital in firm relationship to medical schools has at the same time hidden the VA medical effort under the umbrella of the medical school. With no sense of criticism, but to identify a fact, I affirm that the contribution of VA medicine is one of the best kept secrets in the United States. The close liaison with the medical school should continue and increase; however, a national facility devoted to demonstrating excellence in clinical medicine, a national graduate medical center, would serve to identify, to the public and to the profession, the vigor and quality of VA medicine.

A premium residency stipend should be anticipated inasmuch as the primary objective of the program is to make it feasible for the physician to leave his practice in order to improve his ability. This will require a basic salary, at today's standards, of approximately $1,000 per month. This is not an exceptional stipend, and one must not forget that these residents will be bringing to the VA the mature medical effort of a physician fresh from a successful practice. Also, the fact that a percentage of these sabbatical-leave physicians could conceivably be recruited into a career VA position warrants an extra investment in stipend. If the National Graduate Medical Center could be developed in very close liaison to a medical school and especially to the department of medicine of a medical school, it is conceivable that senior residents in medicine could participate in a locum tenens program, coordinated with the sabbatical-leave residences.

A small number of well-prepared foreign physicians should be selected each year for residency-positions at the National Graduate Medical Center. A subcommittee at the national advisory committee could have responsibility for this selection. These should be physicians who are obligated to return to a teaching center in their own country. The advantages of their presence in the residency program are several. First, to their benefit would be the opportunity of training at an institution which guarantees a high devotion to educational content. This should be compared to the many existing programs where the foreign physician is often used as ready, inexpensive labor. The advantage of correlating the selection of these physicians with existing overseas government programs is apparent.

Initially, one might criticize this suggestion of placing non-American physicians in a facility offering care to the American veterans. Such criticism could be overcome by pointing out that the number of overseas physicians would be small; even more important, they would be carefully selected, outstanding men, and the demonstration of outstanding clinical care would be the basic purpose of all teaching at the center.

In fact, the presence at the National Graduate Medical Center of the foreign physician should be deliberately cultivated. He would be a unique stimulus in the program. My own 25 years of graduate medicine have convinced me that an "international flavor" can be a prime factor in creating a stimulating program.

This last-named item, for which the word "atmospheric" is suggested, lends to the principal ingredient which will make such a graduate center effective. The atmosphere must be one which understands the hesitancies of the older student. The sabbatical-leave physician will have come from a busy life where he has been "in charge." secure, and relatively supreme. When he again puts on "white" and lets others challenge him, it will take a very thoughtful faculty to make him comfortable in the life of give-and-take. Here again, the foreign physician is deliberately brought into the scheme, as a partial antidote. The sabbatical-leave U.S. physician will quickly identify himself in the role as teacher to the foreign physician, and when this is done, the major step towards atmosphere is gained.

The National Graduate Medical Center would be a logical site for a major physician's assistant program. By bringing physicians from practice into an exposure to the physician's assistant concept, one could anticipate that fruitful liaisons could develop between these members of the health team. In fact, in many cases the physician would return to practice accompanied by a physician assistant, met and appreciated while the physician was in his sabbatical-leave residency.

Another value of the graduate center would be obtained if such functions could be coordinated with the biomedical communication activities of the National Library of Medicine. Specifically, the graduate center could be one of the national bases for much of the video-taped material to be distributed through the National Library of Medicine. The graduate center could be a primary "studio" for the National Medical Audiovisual Center, and seminars, panels, outpatient activities, operating rooms, ward rounds, autopsies, x-ray conferences, could all originate from this graduate center.

Ward rounds, with the finest clinician-teachers performing as visiting clinicians, could provide a ready, always current, unrehearsed, open window on medicine. Cameras and audiovisual staff would be a permanent part of the center. The National Library of Medicine and the VA already have sufficient congressional authorization to accomplish this. The National Library of Medicine and the Regional Medical Program offer the vehicle for the national distribution of filmed and taped material.

In summary and for emphasis, the present situation as the proposed program may be outlined as follows:

CONTINUING EDUCATION OF PHYSICIANS

1. There is a generally recognized shortage of postgradute training facilities for the continuing education of the practicing physician.
2. An especial weakness of almost all present attempts in the continuing medical education field is that most teaching efforts are short-term, one- to five-day seminars, refresher courses, etc.
3. There is a real need for organized, sustained bedside- and ambulatory-care teaching programs of one month to one year duration for the practicing physician.
4. Medical schools, the AMA, the American Association of Medical Colleges, the National Library of Medicine, the National Institutes of Health, and the medical specialty colleges, although all interested and all able to make varying contributions, each and all have other primary interests and functions.
5. A medical care facility with beds and outpatients, primarily used for continuing education of physicians, does not exist in the United States.

FOREIGN PHYSICIANS IN THE UNITED STATES

1. The foreign physician is eager for U.S. medical training. Our country has become for medicine, the Vienna of our time.
2. He has found it increasingly difficult to obtain first-class clinical training in this country.

3. He has often ended up as a "service unit" in a very inadequate institution.

4. Or he has been able to get to a first-class institution but has accomplished this by taking on a technical research role which serves him poorly as preparation for return to his home country.

5. Our own country suffers in the long run when the disappointed physician returns to his country, smarting under the realization that this country did not offer him the opportunity that he knows is here, and he is still unprepared for service in his own country.

6. Therefore, a formally organized, clinically oriented, well-supervised, foreign-graduate-physician program would be a major national asset.

7. Such a program would augment existing overseas efforts of both federal and private agencies.

VETERANS' ADMINISTRATION HOSPITALS

1. The VA patient population is stratifying into certain chronic disease categories, and a period of stagnation and somnolence in terms of attracting and holding competent physicians seems inevitable.

2. The basic care of the veteran patient will deteriorate as the physician staff deteriorates. Therefore, a program which would improve veteran patient care would be able to gain endorsement by all interested groups.

3. The VA hospital system represents one of the best physical assets in the health field in the world.

4. It is too valuable a physical asset to permit it to be *underused*.

5. If a carefully chosen VA hospital could be designated a national graduate medical center and its effort devoted to outstanding patient care, graduate clinical instruction, and clinical investigation, I believe this could become an immediate national asset.

6. Cooperative efforts with the National Library of Medicine, the National Medical Audiovisual Center and the Regional Medical Program could, through a journal, films, video tapes, and eventually a health satellite, extend the National Graduate Medical Center's influence on clinical medicine of the entire nation. The center could become the workshop for the "university without walls."

[No. 27]

COMMITTEE ON VETERANS' AFFAIRS, UNITED STATES SENATE

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., August 4, 1971.

Hon. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This will respond to your request for a report by the Veterans' Administration on S. 2355, 92d Congress, the "Veterans' Administration Continuing Medical Education Act."

The subject bill would amend chapter 73 of title 38, United States Code, by adding a new subchapter III providing for the designation by the Administrator of four regional medical education centers. These centers would be used in carrying out the Administrator's functions under section 4101 of title 38 with regard to training of health manpower and would be, to the extent feasible, located in geographically dispersed areas of the United States.

Each regional medical education center would provide continuing medical and related education programs for medical and health personnel for the Veterans' Administration and, to the extent that the Administrator determines such facilities are available, for others on a reimbursable basis. Each center would provide in residence, intensive, advanced training of the highest caliber. Such training would include, but not be limited to (1) the teaching of newly developed medical skills and the use of newly developed medical technologies and equipment, (2) advanced clinical instruction, (3) the opportunity for conducting clinical investigations, and (4) routine verification and, where determined necessary, remediation of deficient, basic medical skills.

Provision is specifically made in this bill for the supervision and staffing of such centers under the direct supervision of the Chief Medical Director through the Assistant Chief Medical Director for Research and Education. Various means are provided in the bill for staffing these centers both from within the Department of Medicine and Surgery and including contracting for the services of eminently qualified medical personnel from outside the Veterans' Administration to serve as instructors at the centers. Personnel eligible for training is left to the determination of the Chief Medical Director with preference being given to career personnel of the Department of Medicine and Surgery. Eligibility for training will also be made available to medical care personnel from other Federal elements on a reimbursable basis. Additionally, non-Federal personnel may also be afforded training to the extent that such facilities are available, also on a reimbursable basis.

This proposal provides for the Chief Medical Director to consult with and seek the advice of the advisory group provided for under section 4112 of title 38.

The Veterans' Administration currently has authority, and has for years engaged in a program of continuing education for its staff as an integral part of the operation of the Department of Medicine and Surgery. This activity was reaffirmed in the Government Employees Training Act (now contained in chapter 41 of title 5). For years, we have been authorized, by congressional appropriations to provide Department of Medicine and Surgery employees with postgraduate and inservice training. Moreover, subsection 4101(b) of title 38 clearly recognizes a program of training and education of health service personnel as one of the functions of the Department of Medicine and Surgery of the Veterans' Administration, and since 1968 we have been authorized to share medical information with medical schools, hospitals, research centers, and individual members of the medical profession under the exchange of medical information program authorized by section 5054 of title 38. We believe that these existing authorities, particularly if they are amended as provided in section 201 of S. 1924, are ample to accomplish all of the purposes set forth in S. 2353.

It is estimated that under the provisions of this bill, the cost of one Regional Medical Education Center for a full operational year will be approximately $400,000. Should the bill be enacted and funds made available by January 1 of this fiscal year, the necessary initial staffing modernization (exclusive of major construction) and equipment purchases could be accomplished by about June 30, 1972, at a rate of about $200,000 a center. Since the bill requires at least four such centers be established, the minimum cost for fiscal year 1972 would be about $800,000.

As noted above, we feel that we currently have sufficient authority to accomplish the purposes of S. 2355, and, accordingly, we do not favor its enactment.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Donald E. Johnson,
Administrator.

Vet. Letters 92–27

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, D.C., August 16, 1971.

Hon. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request for the views of this office on S. 2355, the Veterans' Administration Continuing Medical Education Act.

This bill would provide for the designation by the administrator of Veterans' Affairs of four regional medical centers for purposes of special advanced training activities.

In its report on S. 2355, the Veterans' Administration notes that it currently has sufficient authority to accomplish the purposes of S. 2355 and therefore does not favor its enactment. We concur in the views expressed by the Veterans' Administration and, accordingly, do not favor enactment of S. 2355.

Sincerely,

WILFRED H. ROMMEL,
Assistant Director for Legislative Reference.

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C., October 1, 1971.

Hon. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: With respect to your request of August 18, 1971, for our views on S. 2355, 92d Congress, which would be cited as the Veterans 'Administration Continuing Medical Education Act, this is to advise that we have no comment to offer.

Sincerely yours,

PAUL G. DEMBLING,
Acting Comptroller General of the United States.

[No. 85]

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
January 24, 1972.

Hon. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs, U.S. Senate,
Washington, D.C.

DEAR MR. CHAIRMAN: This letter is in response to your request of July 30, 1971, for a report on S. 2355, a bill to amend title 38, United States Code, so as to afford advanced residency-type training to medical personnel of the Veterans' Administration and other Federal departments and agencies at regional medical centers established at Veterans' Administration hospitals throughout the United States.

The objective of the bill to strengthen training programs which can assist the Veterans' Administration to meet its statutory responsibilities for medical care and treatment of veterans and to enhance the continuing education efforts of the Veterans' Administration. Therefore, we defer to the Veterans' Administration as to the need for this legislation to accomplish this objective.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the administration's program.

Sincerely,

ELLIOT LEE RICHARDSON, *Secretary.*

92d CONGRESS
1st Session

S. 1924

IN THE SENATE OF THE UNITED STATES

May 21, 1971

Mr. Hartke (for himself, Mr. Cranston, and Mr. Thurmond) (by request) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38 of the United States Code to provide improved medical care to veterans; to improve recruitment and retention of career personnel in the Department of Medicine and Surgery, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Veterans Medical Care Act of 1971".

TITLE I—AMENDMENTS TO CHAPTER 17 OF TITLE 38, UNITED STATES CODE—HOSPITAL, DOMICILIARY, AND MEDICAL CARE

Sec. 101. Subparagraph (C) of section 601 (4) of title 38, United States Code, is amended to read as follows:

"(C) private facilities for which the Administrator

II

contracts in order to provide (i) hospital care or medical services for persons suffering from service-connected disabilities or from disabilities for which such persons were discharged or released from the active military, naval, or air service; (ii) hospital care for women veterans of any war; or (iii) hospital care for veterans of any war in a State, Territory, Commonwealth, or possession of the United States not contiguous to the forty-eight contiguous States, except that the annually determined average hospital patient load per thousand veteran population hospitalized at Veterans' Administration expense in Government and private facilities in each such noncontiguous State may not exceed the average patient load per thousand veteran population hospitalized by the Veterans' Administration within the forty-eight contiguous States; but authority under this clause (iii) shall expire on December 31, 1978."

SEC. 102. Subsection (f) of section 612 of title 38, United States Code, is amended to read as follows:

"(f) The Administrator may also furnish medical services for a non-service-connected disability under the following circumstances:

"(1) Where such care is reasonably necessary in preparation for hospital admission, or where such care is reasonably necessary for a veteran who is determined to need hospital care if not treated.

"(2) Where a veteran has been granted hospital care, and outpatient care is reasonably necessary to complete treatment incident to such hospital care.

"(3) Where a veteran of any war has a total disability permanent in nature from a service-connected disability."

TITLE II—AMENDMENTS TO CHAPTER 73 OF TITLE 38, UNITED STATES CODE—DEPARTMENT OF MEDICINE AND SURGERY

SEC. 201. Subsection (b) of section 4101 of title 38, United States Code, is amended to read as follows:

"(b) In order to carry out more effectively the primary function of the Department of Medicine and Surgery to provide a complete medical and hospital service for the medical care and treatment of veterans and to assist in providing an adequate supply of health service personnel to the Nation, the Administrator shall, to the extent feasible without interfering with the medical care and treatment of veterans, develop and carry out a program of training and education of such health service personnel, acting in cooperation with schools of medicine, dentistry, osteopathy, and nursing; other institutions of higher learning; medical centers; hospitals; and such other public or nonprofit agencies, institutions, or organizations as the Administrator deems appropriate."

SEC. 202. Section 4103 (a) of title 38, United States Code, is amended—

(a) by amending paragraph (4) to read as follows:

"(4) Not to exceed eight Assistant Chief Medical Directors, who shall be appointed by the Administrator upon the recommendations of the Chief Medical Director. At least two Assistant Chief Medical Directors may be individuals qualified in the administration of health services who are not doctors of medicine, dental surgery, or dental medicine. One assistant Chief Medical Director shall be a qualified doctor of dental surgery or dental medicine who shall be directly responsible to the Chief Medical Director for the operation of the Dental Service."; and

(b) by amending paragraph (7) to read as follows:

"(7) A Director of Pharmacy Service and a Director of Dietetic Service, appointed by the Administrator."

SEC. 203. (a) Subsections (a) and (b) of section 4107 of title 38, United States Code, are amended to read as follows:

"(a) The per annum full-pay scale or ranges for positions provided in section 4103 of this title, other than

Chief Medical Director and Deputy Chief Medical Director, shall be as follows:

"SECTION 4103 SCHEDULE

"Associate Deputy Chief Medical Director, $36,000.

"Assistant Chief Medical Director, $37,624.

"Medical Director, $32,546 minimum to $36,886 maximum.

"Director of Nursing Service, $32,546 minimum to $36,886 maximum.

"Director of Chaplain Service, $28,129 minimum to $35,633 maximum.

"Director of Pharmacy Service, $28,129 minimum to $35,633 maximum.

"Director of Dietetic Service, $28,129 minimum to $35,633 maximum.

"(b) (1) The grades and per annum full-pay ranges for positions provided in paragraph (1) of section 4104 of this title shall be as follows:

"PHYSICIAN AND DENTIST SCHEDULE

"Director grade, $28,129 minimum to $35,633 maximum.

"Executive grade, $26,143 minimum to $33,982 maximum.

"Chief grade, $24,251 minimum to $31,523 maximum.

"Senior grade, $20,815 minimum to $27,061 maximum.

"Intermediate grade, $17,761 minimum to $23,089 maximum.

"Full grade, $15,040 minimum to $19,549 maximum.

"Associate grade, $12,615 minimum to $16,404 maximum.

"NURSE SCHEDULE

"Director grade, $24,251 minimum to $31,523 maximum.

"Assistant Director grade, $20,815 minimum to $27,061 maximum.

"Chief grade, $17,761 minimum to $23,089 maximum.

"Senior grade, $15,040 minimum to $19,549 maximum.

"Intermediate grade, $12,615 minimum to $16,404 maximum.

"Full grade, $10,470 minimum to $13,611 maximum.

"Associate grade, $9,026 minimum to $11,735 maximum.

"Junior grade, $7,727 minimum to $10,049 maximum.

"(2) No person may hold the director grade in the 'Physician and Dentist Schedule' unless he is serving as a director of a hospital, domiciliary, center, or outpatient clinic (independent). No person may hold the executive grade unless he holds the position of chief of staff at a hospital, center, or outpatient clinic (independent), or comparable position."

(b) The provisions of section 5308 of title 5, United States Code, shall apply to payments made under this section.

SEC. 204. Section 4107 of title 38, United States Code, is further amended by adding at the end thereof the following new subsection:

"(d) (1) In addition to the basic compensation provided for nurses in subsection (b) (1) of this section, a nurse shall receive additional compensation as provided by paragraphs (2), (3), (4), and (5) of this subsection.

"(2) A nurse performing service on a tour of duty, any part of which is within the period commencing at 6 postmeridian and ending at 6 antemeridian, shall receive additional compensation for each hour of service on such tour not exceeding eight hours, at a rate equal to 10 per centum of the employee's basic hourly rate, provided that four hours or more of that tour fall between 6 postmeridian and 6 antemeridian. When fewer than four hours fall between 6 postmeridian and 6 antemeridian, the nurse shall be paid the differential for each hour of work performed between those hours.

"(3) A nurse performing service on a tour of duty, any part of which is within the period commencing at midnight Saturday and ending at midnight Sunday, and which part is not overtime work, shall receive additional compensation for each hour of service on such tour not exceeding eight hours, at a rate equal to 25 per centum of the employee's basic hourly rate.

"(4) A nurse performing service on a holiday designated by Federal statute or Executive order, shall receive such employee's regular rate of basic pay, plus additional pay at a rate equal to such regular rate of basic pay, for that holiday work which is not overtime work.

"(5) A nurse performing officially ordered or approved hours of service in excess of forty hours in an administrative workweek, or in excess of eight hours in a day, shall receive overtime pay for each hour of such additional service; the overtime rate shall be one and one-half times the employee's basic hourly rate, not to exceed one and one-half times the basic hourly rate for the minimum rate of Intermediate grade of the Nurse Schedule. For the purposes of this paragraph, overtime must be of at least fifteen minutes duration in a day to be creditable for overtime pay. Compensatory time off in lieu of pay for service performed under the provisions of this paragraph shall not be permitted. Any excess service performed under this paragraph on a day when service was not scheduled for such nurse, or for which such nurse is required to return to her place of employment, shall be deemed to be a minimum of two hours in duration.

"(6) For the purpose of computing the additional compensation provided by paragraph (2), (3), (4), or (5) of this subsection, a nurse's basic hourly rate shall be derived by dividing the annual rate of basic compensation by two thousand and eighty.

"(7) Any additional compensation paid pursuant to this subsection shall not be considered as basic compensation for the purposes of subchapter VI and section 5595 of subchapter IX of chapter 55, chapter 81, 83, or 87 of title 5, or other benefits based on basic compensation."

SEC. 205. Section 4114 (a) of title 38, United States Code, is amended by striking out the words "ninety days" in the last sentence of paragraph (3) (A) and inserting in lieu thereof "one year".

SEC. 206. Section 4116 of title 38, United States Code, is amended—

(1) by amending subsection (a) to read as follows:

"(a) The remedy—

"(1) against the United States provided by sections 1346 (b) and 2672 of title 28, or

"(2) through proceedings for compensation or other benefits from the United States as provided by any other law, where the availability of such benefits precludes a remedy under sections 1346 (b) or 2672 of title 28,

for damages for personal injury, including death, allegedly arising from malpractice or negligence of a physician, den-

tist, nurse, pharmacist, or paramedical (for example, medical and dental technicians, nursing assistants, and therapists) or other supporting personnel in furnishing medical care or treatment while in the exercise of his duties in or for the Department of Medicine and Surgery shall hereafter be exclusive of any other civil action or proceeding by reason of the same subject matter against such physician, dentist, nurse, pharmacist, or paramedical or other supporting personnel (or his estate) whose act or omission gave rise to such claim.";

(2) by striking out the last sentence in subsection (c) and inserting in lieu thereof the following: "After removal the United States shall have available all defenses to which it would have been entitled if the action had originally been commenced against the United States. Should a United States district court determine on a hearing on a motion to remand held before a trial on the merits that the employee whose act or omission gave rise to the suit was not acting within the scope of his office or employment, the case shall be remanded to the State court."; and

(3) by adding at the end thereof the following new subsection:

"(e) The Administrator may, to the extent he deems appropriate, hold harmless or provide liability insurance for any person to which the immunity provisions of this section apply (as described in subsection (a)), for damage for personal injury or death, or for property damage, negligently caused by such person while furnishing medical care or treatment (including the conduct of clinical studies or investigations) in the exercise of his duties in or for the Department of Medicine and Surgery, if such person is assigned to a foreign country, detailed to a State or political division thereof, or is acting under any other circumstances which would preclude the remedies of an injured third person against the United States provided by sections 1346 (b) and 2672 of title 28, for such damage or injury."

SEC. 207. Section 4117 of title 38, United States Code, is amended to read as follows:

"The Administrator may enter into contracts to provide scarce medical specialist services at Veterans' Administration facilities with medical schools, clinics, and any other group or individual capable of furnishing such services (including, but not limited to, services of physicians, dentists, nurses, technicians, and other medical support personnel)."

TITLE III—AMENDMENTS TO CHAPTER 81 OF TITLE 38, UNITED STATES CODE—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY

SEC. 301. Chapter 81 of title 38, United States Code, is amended by inserting at the end of the first sentence in subsection (a) of section 5012 thereof the following: "Any lease made pursuant to this subsection to any public or nonprofit organization may be made without regard to the provisions of section 5 of title 41. Notwithstanding section 303b of title 40 or other provision of law, a lease made pursuant to this subsection to any public or nonprofit organization may provide for the maintenance, protection, or restoration, by the lessee, of the property leased, as a part or all of the consideration for the lease."

SEC. 302. (a) Chapter 81 of title 38, United States Code, is amended by—

(1) striking out in the first sentence of subsection (a) of section 5053 immediately after the parenthesis the words "or medical schools" and inserting immediately after the close parenthesis the words "or medical schools or clinics"; and

(2) inserting immediately after section 5053 the following new section:

"§ 5053A. Use of excess hospital beds

"In addition to the authority granted under section 5053 of this title, the Administrator may, when he determines it to be in the best interest of the prevailing standards of the Veterans' Administration medical care program, make arrangements, by contract or other form of agreement, between Veterans' Administration hospitals and other hospitals (or other medical installations having hospital facilities) or medical schools or clinics in the medical community, for the use of hospital beds, with supporting services, when not needed for the care and treatment of veterans."

(b) The table of headings at the beginning of chapter 81 of title 38 is amended by inserting immediately after

"5053. Specialized medical resources."

the following:

"5053A. Use of excess hospital beds."

SEC. 303. (a) Chapter 81 of title 38, United States Code, is amended by striking out section 5056 thereof and inserting in lieu thereof the following:

"§ 5056. Coordinating with and participating in programs carried out under the Heart Disease, Cancer, and Stroke Amendments of 1965

"The Administrator, to the extent feasible without interfering with the medical care and treatment of veterans, is authorized to participate in programs under title IX of the

Public Health Service Act, and the Administrator and the Secretary of Health, Education, and Welfare shall, to the maximum extent practicable, coordinate programs carried out under this subchapter and programs carried out under such title IX of the Public Health Service Act."

(b) The analysis of such chapter 81 is amended by striking out

"5056. Coordination with programs carried out under the Heart Disease, Cancer, and Stroke Amendments of 1965."

and inserting in lieu thereof the following:

"5056. Coordinating with and participating in programs carried out under the Heart Disease, Cancer, and Stroke Amendments of 1965."

TITLE IV—AMENDMENT TO CHAPTER 3 OF TITLE 38, UNITED STATES CODE—VETERANS' ADMINISTRATION; OFFICERS AND EMPLOYEES

SEC. 401. (a) Section 234 of title 38, United States Code, is amended by inserting immediately after the words "telephones for" the words "nonmedical directors of centers, hospitals, independent clinics, domiciliaries, and".

(b) The table of sections at the beginning of chapter 3 of title 38, United States Code, is amended by deleting

"234. Telephone service for medical officers."

and inserting in lieu thereof:

"234. Telephone service for medical officers and facility directors."

[No. 20]

COMMITTEE ON VETERANS' AFFAIRS, UNITED STATES SENATE

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., July 27, 1971.

Hon. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This will respond to your request for a report by the Veterans' Administration on S. 1924, 92d Congress, a bill "To amend title 38 of the United States Code to provide improved medical care to veterans; to improve recruitment and retention of career personnel in the Department of Medicine and Surgery, and for other purposes."

The subject bill is identical to a draft bill which I submitted to the President of the Senate by letter dated May 3, 1971, a copy of which is enclosed for your convenient reference. The views expressed therein are equally applicable to S. 1924, and I would therefore urge early and favorable consideration of that bill by your committee.

We were advised by the Office of Management and Budget in connection with the draft bill that there was no objection from the standpoint of the Administration's program to the submission thereof to Congress.

Sincerely,

DONALD E. JOHNSON,
Administrator.

[No. 9]

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

Veterans' Administration,
Office of the Administrator of Veterans' Affairs,
Washington, D.C., May 3, 1971.

Hon. Spiro T. Agnew,
President of the Senate,
Washington, D.C.

Dear Mr. President: There is transmitted herewith a draft bill "To amend title 38 of the United States Code to provide improved medical care to veterans; to improve recruitment and retention of career personnal in the Department of Medicine and Surgery; and for other purposes," with the request that it be introduced in order that it may be considered for enactment.

In view of the large number of sections and the wide area of medical care and medical personnel administration covered by the draft bill, we are enclosing a detailed analysis and cost estimate of each section of the proposed bill, together with an enclosure showing the changes proposed to be made in current laws. Briefly, however, the draft bill would:

(1) extend the long-standing statutory definition of the term "Veterans' Administration facility" to include private facilities under contract to provide outpatient care for service-connected disabilities;

(2) provide statutory basis for furnishing pre-hospital, post-hospital, and out-patient care which might expedite or avoid hospital care;

(3) clarify the Administrator's authority to furnish training and education to health service personnel beyond the direct needs of the Department of Medicine and Surgery;

(4) make adjustments in salary and positions of certain Department of Medicine and Surgery personnel and provide differential pay for nurses;

(5) clarify contracting authority for scarce medical specialists;

(6) clarify and extend malpractice liability protection for medical personnel; and

(7) expand medical sharing agreement authority and permit a VA facility to participate in certain programs under the Public Health Service Act.

If enacted, the total first-year cost to the Government of the draft bill would be approximately $16.1 million.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this draft bill to the Congress from the standpoint of the Administration's program.

Sincerely,

Donald E. Johnson,
Administrator.

Enclosure.

SECTION-BY-SECTION ANALYSIS AND ESTIMATE OF COST OF DRAFT BILL VETERANS MEDICAL CARE ACT OF 1971

TITLE I—AMENDMENTS TO CHAPTER 17 OF TITLE 38, UNITED STATES CODE—HOSPITAL, DOMICILIARY, AND MEDCAL CARE

SECTION 101

This section would amend subparagraph (C) of section 601(4), title 38, to reflect in the definition of "Veterans' Administration facilities" the long-standing statutory construction of the term to include private facilities for which the Administrator contracts to provide outpatient care for service-connected disabilities. The amendment will not create a new benefit nor expand the outpatient care program nor would there be any additional cost.

SECTION 102

This section would amend subsection (f) of section 612 of title 38, *to* authorize the Administrator to furnish medical services for a non-service-connected disability where (1) such care is reasonably necessary in preparation for hospital admission or obviate the need for hospital admission; (2) a veteran has been granted hospital care, and outpatient care is reasonably necessary to complete treatment; or (3) any veteran of any war who has a total disability permanent in nature from a service-connected disability.

Section 612(f)(1) as added by Public Law 86-639, authorizes outpatient treatment for a non-service-connected disability where such care is reasonably necessary in preparation for admission of a veteran who has been determined to need hospital care and who has been scheduled for admission.

The objectives of that legislation were reduction in the length of patient stay in the hospital, decrease in the cost per patient treated, and a partial check on the development of longer waiting lists as the veteran population ages. While, generally, such benefits have been realized during the period the law has been in force, certain restrictive provisions in the current law serve as an impediment to fuller achievement of these worthwhile goals. Medical services furnished must be limited to those necessary to prepare the patient for hospital care for which he has actually been scheduled.

There is a sizable number of applicants whose need for hospitalization cannot definitely be determined after routine examination. This group frequently requires extensive workup and recalls for consultation to confirm or rule out requirement for hospitalization. Realistically, such procedures often go beyond the need to determine hospital care and constitute treatment.

The provisions in revised section 612(f)(1) will result in a more timely treatment of veterans on an outpatient basis whom the VA admitting physician has certified would otherwise require admission to a VA hospital. It is estimated that enactment of this provision would entail no additional cost to the VA hospital system, but it may generate modest savings.

TITLE II—AMENDMENTS TO CHAPTER 73 OF TITLE 38, UNITED STATES CODE—DEPARTMENT OF MEDICINE AND SURGERY

SECTION 201

This section would amend section 4101 of title 38 by amending subsection (b) thereof to make it clear that the Administrator can furnish training and education to health service personnel beyond the direct needs of the Department of Medicine and Surgery and thus assist in providing an adeqaute supply of such personnel to meet the needs of the Nation to the extent that this is feasible without interfering with the medical care and treatment of veterans.

Section 4101 of title 38 now specifically identifies education and training as a functional responsibility of the Department of Medicine and Surgery. The programs authorized, however, are limited to those which bear reasonable relationship to the basic mission of the Department; namely, the medical care and treatment of veterans. This authority, together with the provisions of section 5053 of title 38, has done much to support the education and training programs of the Veterans' Administration and to permit greater participation with the medical community in a more effective utilization of specialized medical resources. Nevertheless, the limitation imposed on our education and training program does, in some measure, impede our ability to realize our full potential for carrying out programs to increase the availability of qualified health service personnel to meet the needs of the Nation.

The Veterans' Administration is affiliated with a number of educational institutions, including 79 medical schools, 55 dental schools, 254 nursing schools, 73 social work schools, and 74 graduate departments of psychology. It is manifest that the extensive nature of the Veterans' Administration's medical program, together with this broad basis of affiliation with educational institutions, presents an unusual opportunity to contribute to a program of training and education of health service personnel and thereby make a substantial contribution in alleviating the national shortage in these categories of employees.

The provisions of present law limiting the Veterans' Administration education and training functions to those which bear reasonable relationship to the medical care and treatment of veterans render it impossible to make the maximum contribution to the Nation's objective to increase the medical manpower.

There would be no necessary additional cost as the result of the enactment of this amendment. The actual cost would be dependent upon the training possibilities which develop and the support given the activity by the Congress through appropriations.

SECTION 202

This section amends subsection 4103(a)(4) of title 38 to provide for the appointment by the Administrator, upon recommendation by the Chief Medical Director, of two additional Assistant Chief Medical Directors who are qualified in the Administration of health services and who may not be doctors of medicine, dental surgery, or dental medicine.

Under the provisions of Public Law 293, 79th Congress, enacted January 3, 1946, there were authorized not to exceed eight Assistant Chief Medical Directors in the Department of Medicine and Surgery. This number was reduced to five by Public Law 87–793 but increased to six in 1966 by Public Law 89–785. Hence, the net effect of the proposed amendment would be to restore the number of Assistant Chief Medical Directors to eight as previously provided although, for the first time, providing that two of them may not necessarily be physicians or dentists.

The expansion in the type of complex medical programs has concomitantly fostered an increased awareness of the necessity for sophisticated management techniques in implementing these programs. An organization as large and dispersed as the Department of Medicine and Surgery of the Veterans' Administration, with an annual budget of almost $2 billion, requires a wide range of specialized disciplines. To this end, the Chief Medical Director should have the option available to him to appoint individuals basically trained in management disciplines, with or without qualifications as doctors of medicine or dentistry. These individuals would supplement the professional skills of the medical Assistant Chief Medical Directors and would provide the Chief Medical Director with the full range of expertise needed to efficiently administer the agency's far-flung medical activities.

The gross cost resulting from enactment of this section would be approximately as follows:

1972	$75,000
1973	80,000
1974	85,000
1975	90,000
1976	95,000
Total first 5-year cost	425,000

These costs would be to some extent offset by savings in salary of classified personnel now performing related duties.

This section also amends section 4103(a)(7) in order to conform the titles "Chief Pharmacist" and "Chief Dietitian" to reflect new designations of Director of the Pharmacy Service and Director of the Dietetic Service to correspond to the other Director of Services titles, such as Chaplain and Nursing.

SECTION 203

This section would amend subsections (a) and (b) of section 4107 of title 38, in order to reflect the adjustment in rates of pay effected by Executive Order 11576, dated January 8, 1971, pursuant to authority vested by subchapter I of chapter 53 of title 5, as amended by the Federal Pay Comparability Act of 1970, and section 3(c) of that Act.

The per annum full-pay scale or ranges for positions in this amended schedule in excess of $36,000 are limited by section 5308 of title 5, as added by the Federal Pay Comparability Act of 1970, to the rate for level V of the Executive Schedule (as of the date of the Executive Order, $36,000).

Moreover, this section would amend the "section 4103 schedule" contained in section 4107(a) by providing that the salary range for the

Director of Nursing Service would be changed from the equivalent of GS–15 to the equivalent of GS–17 and for the Director of Chaplain Service, the Director of Pharmacy Service, and the Director of Dietetic Service from the equivalent of GS–15 to the equivalent of GS–16. The VA in conjunction with the Civil Service Commission recently completed a study of these positions with a view to determine in particular the appropriateness of linkage in pay between the position of Director of Nursing Service and grade GS–15 under the General Schedule. It was the conclusion in this study that the position of Director of Nursing Service was clearly superior to GS–15 in level. The proposed adjustment in pay for the positions indicated is essential for alignment purposes and recognition of their individual responsibilities. The titles of Chief Pharmacist and Chief Dietitian are changed to that of Director of Pharmacy Service and Director of Dietetic Service, respectively, in order to parallel the existing titles for Director of Nursing Service and Director of Chaplain Service.

It is estimated that enactment of this portion of section 203 would result in an additional annual cost to the Government of approximately $10,500.

The joint study by the Veterans Administration and the Civil Service Commission also revealed that certain other nurse positions of those presently in the Assistant Director Grade, which equates in pay to grade GS–14 under the General Schedule, were superior to that grade relationship. Accordingly, the purpose of the new Director grade inserted in the "Nurse Schedule" by this amendment is necessary to recognize those positions. The pay range provided is equivalent to that of GS–15 under the General Schedule.

It is estimated that enactment of this part of section 203 would cost an additional $42,000 annually.

Subsection (b)(2) of section 4107 is amended to confine the prohibition against any person in the director grade serving in any other position than director of a hospital, domiciliary, center, or outpatient clinic (independent) to the "Physician and Dentist Schedule," in order to accomplish the purpose of the amendment creating a director grade in the "Nurse Schedule."

SECTION 204

This section would provide that a nurse performing (1) service on a tour of duty, of which 4 hours or more fall within the period commencing at 6 p.m. and ending at 6 a.m., would receive additional compensation for each hour on such tour, not exceeding 8 hours, at a rate equivalent to 10 percent of the employee's basic hourly rate, and when fewer than 4 hours fall between 6 p.m. and 6 a.m., the nurse would receive an additional 10 percent for each hour of work performed between those hours; (2) nonovertime work on a tour of duty, any part of which is within the period commencing at midnight Saturday and ending at midnight Sunday, would receive additional compensation for each hour of service on such tour, not to exceed 8 hours, at a rate equivalent to 25 percent of the employee's basic hourly rate; (3) service on a holiday designated by Federal status or Executive order, would receive such employee's regular rate of basic pay, plus additional pay at a rate equal to such regular rate of basic pay for that holiday work which is not overtime work; and (4) officially ordered or approved hours of service in excess of 40 hours in an administrative workweek, or in excess of 8 hours in a day, would be paid for each hour of such additional service at a rate of one and one-half times the employees' basic hourly rate; compensatory time off would not be permitted and such overtime work would have to be of at least 15 minutes duration in a day to be creditable for overtime pay; however, excess service performed on a day when service was not scheduled, or for which such nurse is required to return to her place of employment, would be deemed to be a minimum of 2 hours in duration, regardless of whether or not work is performed for the full 2 hours.

This section also provides the formula for converting the per annum basic compensation rate into the hourly rate. Such hourly rate would be derived by dividing the annual rate of compensation by 2080, which represents the average number of working hours per year, and is the same formula used in computing the hourly overtime and night rate of pay for Civil Service employees under title 5, United States Code, where the basic rate of pay of the employee is fixed on an annual basis. Moreover, it provides that "the additional compensation" provided by this section would not be considered basic compensation for purposes of lump sum leave payments, severance pay, compensation for work injury, retirement, life insurance, or other benefits relating to basic compensation.

Under current law Veterans' Administration nurses do not receive premium pay for those conditions of work which are generally regarded as more onerous to employees both within and without the Federal Government. A study of hospital practices shows that non-Federal hospitals almost universally provide extra pay for nurses working on evening and night tours of duty. Also, by law, Federal employees under the General Schedule, Postal Field Service, and prevailing rate systems of pay are entitled to premium pay for such considerations as Sunday and overtime duty.

The Veterans' Administration has found it very difficult to attract and retain qualified nurses for the evening and night tours of duty in many Veterans' Administration hospitals. An impairment of our ability to provide adequate nursing care for our ill and disabled veteran patients could result unless immediate action is taken to strengthen our position in this matter.

Developments in recent years with respect to the matter of nurses' pay in private, community and state hospitals throughout the country make it necessary for the Veterans' Administration, which operates the largest single system of medical facilities in the world, to provide a rounded compensation plan for nurses, including customary provisions for premium pay, in order to remain competitive in attracting and retaining highly qualified nursing personnel.

It is estimated that the annual cost based on present level of salaries, should this amendment be enacted, would be approximately $16 million.

SECTION 205

This section would amend section 4114(a)(3)(A) of title 38 to extend from 90 days to 1 year the present time limit on temporary full-time appointment by the Administrator upon recommendation of the Chief Medical Director, of persons in the Department of Medicine and

Surgery, other than physicians, dentists, and nurses. If amended, this authority would parallel the present 1-year time limit on part-time appointments of these personnel, other than trainees who currently have no time limit for part-time appointment.

The enactment of this proposal would not result in any significant increase in costs.

SECTION 206

This section would clarify and extend the type of malpractice liability protection now provided medical personnel of the VA Department of Medicine and Surgery by the provisions of section 4116 of title 38, United States Code.

Section 4116 provides, in effect, that a suit against the United States under the Federal Tort Claims Act is the exclusive remedy of an individual seeking to recover for injuries arising while undergoing medical care and treatment in a Veterans' Administration hospital. It was intended to immunize the Department of Medicine and Surgery medical personnel who are covered from personal liability arising out of their official VA duties. It has served its purpose well and has been an aid in the recruitment of much-needed medical personnel. Nevertheless, questions have arisen as to the scope of its coverage in certain situations where a suit against the Government cannot now be brought under the Federal Tort Claims Act (e.g., suits alleging assault and battery, libel and slander, false imprisonment, or relating to a work-incurred injury of a Federal employee).

While several recent decisions by the U.S. Court of Appeals for the Sixth and Ninth Circuits (i.e., *Van Houten* v. *Ralls*, 411 F.2d 940 and *Vantrease* v. *United States*, 400 F.2d 853) have added assurance that the type of protection provided by the so-called Drivers Liability Act (upon which the provisions of 38 U.S.C. 4116 were patterned) was intended to immunize the employees covered thereby from personal liability in all situations where they are sued as a result of their official duties (including when they are sued by a fellow employee for a work-related reason), it is believed desirable to spell out authority in the law itself to insure such immunity.

In addition to providing clarifying language as to the intent of the law, the amendment here proposed would provide Department of Medicine and Surgery medical personnel with a type of protection similar to that contained in the National Health Service Corps Act of 1970 (Public Law 91-623), applicable to Public Health Service Personnel. It would authorize the Administrator, to the extent he deems appropriate, to hold harmless or provide liability insurance for any person to which the immunity provisions of 38 U.S.C. 4116 are applicable, where such person might be held liable for damage to property, or personal injury or death, negligently caused while furnishing medical care and treatment (including the conduct of clinical studies or investigations) in the exercise of his duties in or for the Department of Medicine and Surgery, under circumstances where the injured party could not bring an action against the United States as provided by Sections 1346(b) or 2672 of title 28. For example, it would provide a means of protecting Department of Medicine and Surgery medical personnel who are assigned to a foreign country, or who are sued for assault and battery, false imprisonment, or libel and slander in connection with the performance of their assigned duties.

By filling a void which exists in areas where a suit against the Government under the Federal Tort Claims Act may now be precluded, this amendment would provide a means of insuring the immunity from personal liability arising out of the performance of official duties, which Congress intended to provide when the provisions of 38 U.S.C. 4116 were enacted.

While this proposal may result in a slight increase in the Government's exposure to malpractice claims arising out of the activities of our medical personnel, any cost increase which may be involved would be more than offset by the improvement of morale which would result therefrom, and the added inducement in teempting to recruit shortage category health personnel.

SECTION 209

This section would amend section 4117 of title 38, to authorize the Administrator to enter into contracts to provide scarce medical specialist services at Veterans' Administration facilities with medical schools, clinics, and any other group or individual capable of furnishing such services. This contracting authority would include, but not be limited to, services of physicians, dentists, nurses, technicians, and other medical support personnel.

This proposed amendment is intended merely to clarify current law which authorizes such contracting authority with medical schools and clinics. This contracting authority, insofar as clinics are concerned, has been interpreted by the Comptroller General of the United States (B–169747, June 24, 1970) to mean "any medical organization which is capable of contracting for and furnishing the services in question." Moreover, the Comptroller General was of the opinion that the term "medical specialist" may be construed "as including any professional or technician who performs specialist services related to providing medical care and attention."

Enactment of this section would clarify current statutory language whereby the Administrator could contract for scarce medical specialist services with medical schools, clinics, and any other group or individual capable of furnishing such services and wherein an employer-employee relationship is established.

Enactment of this section would not result in any additional cost to the Government.

TITLE III—AMENDMENTS TO CHAPTER 81 OF TITLE 38, UNITED STATES CODE—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY

SECTION 301

This section would amend section 5012(a) of title 38, which permits the Administrator to lease lands or buildings under his control for terms not exceeding 3 years, to exempt such leases from (1) the provisions of section 5 of title 41 requiring advertising where the lease exceeds $500; and (2) from the provisions of section 303b of title 40 which bars lease provisions calling for alteration, repair, or improvement of such leased property as part of the consideration for the rental to be paid. Under the change, the lessee would be permitted to maintain, protect, or restore property where such property is leased to public or nonprofit organizations.

The Veterans' Administration only out-leases property when it is temporarily excess to its needs. We do not lease for strictly commercial purposes, but only for civic, health, educational or local government use. Thus, advertising in these cases serves no useful purpose but does involve time and expense that is considered unnecessary.

When the Veterans' Administration does out-lease property it is most usually to satisfy a particular civic or local community need and is generally to a public or nonprofit organization. In many instances there are benefits, either directly or indirectly, accruing to the Government. Also, there is to be considered the community relations benefits that are derived. In negotiating the rental value we set a rate that will serve to recapture the value of all services provided by the Government. However, in some instances we could be relieved of certain expenses for materials and personnel if we could require the lessee to provide for maintenance and protection of the property leased.

It is estimated that the enactment of this section would not involve any additional cost to the Government, but could result in some savings.

SECTION 302

Subsection (a)(1) of this section would amend section 5053(a) of title 38, by deleting immediately after the parenthesis the words "or medical schools" and inserting immediately after the close parenthesis the words "or medical schools or clinics". Current law (38 U.S.C. 5053) requires that the medical school have hospital facilities before any sharing agreement can be made between the medical school and the Veterans' Administration.

The amendment proposed here would cure this defect and authorize the Administrator to enter into a contract or agreement with a medical school, whether or not it has a hospital, and with clinics, for the mutual use, or exchange of use of specialized medical resources.

Subsection (a)(2) would amend chapter 81 of title 38, United States Code, by adding a new section 5053A authorizing the Veterans' Administration hospitals to furnish, under contract, hospital beds, with supporting services, to other hospitals or other installations having hospital facilities or medical schools or clinics in the medical community, when not needed for the care and treatment of veterans. The authority which would thus be granted would be an extension of our present sharing authority (38 U.S.C. 5053).

In our letter to the Congress on April 23, 1965, requesting enactment of our current sharing authority, we stated:

> While current law permits the use of our facilities by nonveterans in emergencies for humanitarian reasons, we are unable to permit the use of such facilities and equipment, as well as expertise of our staff, for nonemergent situations even if there are no other similar facilities available. This situation exists even though these scarce medical facilities are not always utilized to

> the maximum and could be available to the community, without detriment to the care and treatment of veteran beneficiaries, during periods when our immediate needs do not require maximum utilization.

Although the language of the present authority would appear to be sufficiently broad to encompass the sharing of beds surplus to our needs, as contemplated by the subject bill, this question was resolved by the legislative history of the enactment of the sharing authority. In Senate Report No. 1727, to accompany H.R. 11631, 89th Congress (p. 12), the committee stated:

> Some apprehension has been expressed that the language of this legislation might be construed to authorize the use of Veterans Administration medical care beds by nonveteran patients of private or other Federal facilities on the basis of a shortage of such beds in the medical community. Specifically, there was some concern that the language in section 5052(c) which reads "For the purpose of this section the term "specialized medical resources" means medical resources (whether equipment, space, or personnel) which because of cost, limited availability, or unusual nature, are either unique in the medical community or are subject to effective utilization only through mutual use," would authorize such a construction. Such a broad interpretation was in no way intended by the Veterans Administration in recommending this legislation, nor by this committee in reporting it, and, therefore, would not be permissible. Since the major purpose of this legislation is to strengthen and improve VA hospitals, the committee emphasizes that no provision shall be construed to authorize any reduction in medical services available to veterans.

In view of that language, we have held that we do not have authority to contract with hospitals, medical schools or other medical installations having hospital facilities for the use of our hospital beds, even though such beds are not needed for the care and treatment of veterans.

In a hospital system as large as the Veterans' Administration hospital system, some excess beds will exist which are either staffed or which could readily be staffed. Our experience has shown that in a number of such instances these facilities could have been utilized for the benefit of the community without any interference with our primary mission of meeting the medical care and treatment needs of our veteran beneficiaries. Two examples of such a situation, which occurred during the past year, may be mentioned.

First, a medical school with hospital facilities with which one of our hospitals was affiliated needed some additional bed capacity. There were unused beds available in the Veterans' Administration hospital, but they were not staffed. Those beds could have been activated with the assistance of the staff of the medical school and would thus not only have assisted the community but, at the same time, enhanced Veterans' Administration health care by attracting high caliber personnel interested in the extended training opportunities which would have existed.

The second case involved an affiliated medical school which did not have a hospital and depended on community hospitals for the clinical treatment of medical school patients, and we had beds excessive to our use and, moreover, could have provided certain specialized medical resources had it been permissible to furnish hospital beds for the use of medical school patients. In such a case it would be beneficial to our hospital care program, to the medical school, and to the community if we were in a position to execute an agreement with the medical school as would be authorized by this section.

The type of contract proposed would be subject to the same requirement for reimbursement of full costs to which other types of sharing contracts are now subject. Under those circumstances, increased costs would not be involved and enactment of this section could result in some savings being realized.

SECTION 303

This section would amend section 5056 of title 38, United States Code, to clearly delineate the authority of the Administrator to participate in programs under title IX of the Public Health Service Act, and directs the Administrator, to the maximum extent practicable, to coordinate with the Secretary of Health, Education, and Welfare, programs carried out under subchapter IV of chapter 81 of title 38, and programs carried out under title IX of the Public Health Service Act. Thus, within certain limitations, a Veterans' Administration facility would be eligible to receive funds (through local contracts, agreements, or otherwise) from any institution which is a grantee under section 901(a) of title IX of the Public Health Service Act, and to receive project grants under section 910 of that act.

The Acting Secretary for Health, Education, and Welfare, stated in an opinion dated May 20, 1970, that Veterans' Administration is not precluded from receiving funds (through local contracts, agreements, or otherwise, from any institution which is a grantee under section 901(a) of title IX of the Public Health Service Act provided that the Federal facility on its part is authorized to undertake the activity and so to utilize the funds provided. He further stated that by virtue of section 501 of the Public Health Service Act "research, training, demonstration" project grants may be made direct to Veterans Administration hospitals under title IX of the act, but only to the extent that the services provided by the Veterans' Administration facility, as an affiliate of a regional medical program, constitute a "research, training, demonstration project" to be conducted by the facility as part of a regional medical program. The proposed amendment to section 5056 of title 38 would make it clear that the Administrator is authorized to participate in programs under title IX of the Public Health Service Act and thus utilize grant funds thereunder.

There would be no identifiable additional cost resulting from the enactment of this provision.

TITLE IV—AMENDMENT TO CHAPTER 3 OF TITLE 38, UNITED STATES CODE—VETERANS' ADMINISTRATION; OFFICERS AND EMPLOYEES

SECTION 401

This section amends section 234 of title 38 to permit the installation of official telephone service in the private residences, apartments, or quarters of nonmedical Veterans' Administration hospital, independent clinic, domiciliary, and center directors.

Present law permits such official telephones only for directors who are physicians. This direct service has proven very valuable in (a) local within hospital emergencies, including such instances as berserk patients and employees, shootings, an employee held as a hostage, and the sudden death of a key employee while on duty after hours; (b) local community emergencies such as Hurricane Camille, tornadoes, and train collisions with multiple victims; and (c) national and area civil defense programs where the support, participation, and coordination by each Veterans' Administration hospital director is required on a planned basis. This has permitted direct communication with these key official without having to compete with the normal family telephone. More well-trained non-medical administrators are becoming available to us as hospital, center, clinic and domiciliary directors and we believe that these non-medical directors have as great a need for rapid telephone service in the case of these within-facility, local, or civil defense emergencies as the other directors.

It is estimated that such a proposal would cost approximately $3,000 annually.

[No. 45]

COMMITTEE ON VETERANS' AFFAIRS, UNITED STATES SENATE

Comptroller General of the United States,
Washington, D.C., October 20, 1971.

B-160299.

Hon. Vance Hartke,
Chairman, Committee on Veterans' Affairs, United States Senate, Washington, D.C.

Dear Mr. Chairman: Your letter of August 9, 1971, requests our comments on S. 1924, 92d Congress, which, if enacted, would be cited as "Veterans' Medical Care Act of 1971."

S. 1924 would amend chapters 3, 17, 73, and 71 of title 38, United States Code, to provide improved medical care to veterans, improved recruitment and retention of career personnel in the Department of Medicine and Surgery, and for other purposes.

Section 302(a) of the bill would amend chapter 81 of title 38, United States Code by adding section 5053A. This proposed section provides that the Administrator of Veterans' Affairs may, when he determines it to be in the best interest of the prevailing standards of the VA medical program, make arrangements, by contract or other form of agreement, between VA hospitals and other hospitals or medical schools or clinics in the medical community, for the use of hospital beds, with supporting services, when not needed for the care and treatment of veterans. The authority granted under this section would supplement the authority for sharing of specialized medical resources contained in section 5053 of title 38.

We suggest that the proposed section 5054A include criteria for establishing the basis of reimbursement to VA for the use of VA hospital beds and supporting services by non-VA organizations. The average per diem operating cost for a VA general medical and surgical bed was about $53 during fiscal year 1971.

Sincerely yours,

Robert F. Keller,
Deputy Comptroller General of the United States.

92d CONGRESS
1st Session

S. 2304

IN THE SENATE OF THE UNITED STATES

July 19, 1971

Mr. Tower introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

---

A BILL

To amend title 38, United States Code, to provide financial assistance to institutions for the establishment and expansion of programs under which veterans with military acquired medical skills will be trained and educated in the allied health professions.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Veterans' Allied Health Professions Training Act".

Sec. 2. Chapter 81 of title 38, United States Code, is amended by adding at the end thereof a new subchapter as follows:

II

"SUBCHAPTER V—VETERANS' ALLIED HEALTH PROFESSIONS TRAINING ASSISTANCE PROGRAM

"§ 5061. Purpose

"It is the purpose of this subchapter to authorize the Administrator to carry out a program under which grants shall be made to eligible institutions to establish and expand special training programs for veterans with military acquired medical skills so that such veterans can qualify under State or local law as allied health specialists.

"§ 5062. Definitions

"As used in this subchapter—

"(1) The term 'eligible institution' means any public or private nonprofit education institution, including, but not limited to, colleges, universities, junior colleges, community colleges, and schools of allied health professions. Such term also includes public and private nonprofit hospitals and other health service institutions which train and educate persons in the allied health professions or agree to do so with the assistance provided under this subchapter.

"(2) The term 'military medical skill' means any medical skill currently designated by one or more military departments as a military occupational specialty or skill.

"(3) The term 'eligible veteran' means any veteran who acquired a military medical skill while serving in the Armed Forces.

"§ 5063. Grants to eligible institutions

"(a) The Administrator is authorized, under such rules and regulations as he shall prescribe, to make grants to eligible institutions which agree to use the proceeds of such grants for the purpose of training and educating eligible veterans in the allied health professions. Grants made under this subchapter may be used by any eligible institution to develop, expand, or improve a program of training or education in the field of allied health services if the Administrator determines that eligible veterans will be directly benefited thereby; and the Administrator may impose such terms and conditions on the making of such grants as he deems appropriate to insure that such veterans will be directly benefited by such grants.

"(b) An application for a grant under this subchapter by any eligible institution shall be approved only if the Administrator determines that—

"(1) the proposed purpose for which the grant is to be made will be specifically designed to meet the training and education needs of eligible veterans and, to the maximum extent possible, shall be used only in connection with the training and education of such veterans;

"(2) the application sets forth such fiscal control and accounting procedures as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this subsection; and

"(3) the application provides for making such reports, in such form and containing such information, as the Administrator may require to carry out his functions under this subchapter, and for the keeping by such institution of such records and for affording such access thereto as the Administrator deems necessary to assure the correctness of such reports.

"(c) The Administrator shall require as one of the conditions of eligibility for receiving a grant under this subsection that an eligible institution provide training and education, with respect to the particular allied health specialty or specialties it offers eligible veterans, sufficient in scope and quality to enable eligible veterans completing such training and education to qualify for certification or licensing as allied health personnel under the laws of the State or local jurisdiction in which they plan to utilize such training and education.

"§ 5064. Payments

"Payments made pursuant to grants under this subchapter may be made in installments, either in advance or by way of reimbursement, as the Administrator may determine, with necessary adjustments on account of overpayments or underpayments.

"§ 5065. Authorizations for appropriations

"For the purpose of making grants under this subchapter, there is authorized to be appropriated for the fiscal year ending June 30, 1972, the sum of $2,000,000; and for each of the six succeeding fiscal years the sum of $3,000,000. Funds appropriated under this section shall remain available until the end of the second fiscal year following the fiscal year for which they were appropriated."

SEC. 3. The table of sections at the beginning of chapter 81 is amended by adding at the end thereof the following:

"SUBCHAPTER V—VETERANS' ALLIED HEALTH PROFESSIONS TRAINING ASSISTANCE PROGRAM

"5061. Purpose.
"5062. Definitions.
"5063. Grants to eligible institutions.
"5064. Payments.
"5065. Authorizations for appropriations."

[No. 29]

COMMITTEE ON VETERANS' AFFAIRS, UNITED STATES SENATE

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., August 4, 1971.

Hon. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This will respond to your request for a report by the Veterans' Administration on S. 2304, 92d Congress, a bill cited as the "Veterans' Allied Health Professions Training Act."

This bill would add a new subchapter V to chapter 81 of title 38, United States Code, for the purpose of authorizing the Administrator of Veterans' Affairs to carry out a program under which grants shall be made to eligible institutions to establish and expand special training programs for veterans with military acquired medical skills so that such veterans can qualify under State or local law as allied health specialists.

Under the provisions of the bill, the Administrator would be authorized to make grants to eligible institutions for the purpose of providing training and education of eligible veterans in the allied health professions.

Grants under this bill, under such rules and regulations as the Administrator shall prescribe, could be provided to any public or private nonprofit educational institution not only to the colleges, universities and junior colleges, but also to schools of allied health professions including nonprofit hospitals and other health service institutions which train and educate persons in the allied health professions or who agree to do so with this assistance.

The bill would authorize eligible institutions to use such grants to develop, expand, or improve a program of training or education in such allied health fields, if the Administrator determines that veterans will be directly benefited thereby. To this end, the Administrator is authorized to impose such terms and conditions with respect to such grants as he deems appropriate. Among such requirements will be a determination by the Administrator that the purpose of the grant to be made will be specifically designed to meet the training and education needs of eligible veterans and shall be used for the training and education of such veterans to the maximum extent possible, and that adequate fiscal control and accounting procedures will be used in the disbursement of such funds. In addition, the Administrator shall require that an eligible institution provide training and education sufficient in scope and quality to enable veterans completing such course of education to qualify for a license under the State or local jurisdiction in which they utilize such training.

The bill would authorize an appropriation for such grants for fiscal year 1972 in the sum of $2 million and for each succeeding fiscal year, the sum of $3 million. Funds appropriated for such purpose would remain available until the end of the second fiscal year following the fiscal year for which they were appropriated.

For over 25 years, hospitals of the Veterans' Administration have been offering hospital-based educational experience in collaboration with most of the Nation's medical schools. Veterans' Administration hospitals are currently affiliated with 81 medical schools, 51 dental schools, 287 nursing schools, 274 universities and colleges and 84 community and junior colleges. During the current fiscal year, more than 50,000 students will participate in more than 60 categories of training in Veterans' Administration institutions. Thus, the Veterans' Administration's contribution in the field of health education has been substantial.

The success and productivity of this partnership between an agency of the Government and the non-Federal system of higher education in the interest of the entire health care system has won the confidence and support of all.

However, we do not feel that the placing of grant authority in the Veterans' Administration for the purposes set forth in S. 2304 is the proper approach for expanding medical education facilities in the context of the broad national programs for these objectives. The program envisioned by S. 2304 would duplicate and overlap current authorities under the health professions educational assistance provisions of titles VII and VIII of the Public Health Service Act to assist in the establishment of new schools of medicine, the expansion of existing schools, the provision of operating support under both formula and special project grants, and the training of health service personnel.

As you know, the President has emphasized the need for consolidation and coordination of such granting mechanisms throughout the Federal Government in his "Health Message" to the Congress on February 18, 1971:

* * * * * * *

> "In addition, I believe that Federal support dollars for this construction of medical education facilities can be used more effectively. I recommend that the five current programs in this area be consolidated into a single, more flexible grant authority and that a new program of guaranteed loans and other financial aids be made available to generate over $500 million in private construction loans in the coming fiscal year—five times the level of our current construction grant program.
>
> "Altogether, these efforts to encourage and facilitate the expansion of our medical schools should produce a 50-percent increase in medical school graduates by 1975. We must set that as our goal and we must see that it is accomplished.

* * * * * * *

> "I recommend that our allied health personnel training programs be expanded by 50 percent over 1971 levels, to $29 million, and that $15 million of this amount be devoted to training physicians' assistants. We will also encourage medical schools to train future doctors in the proper use of such assistants and we will take the steps I described earlier to eliminate barriers to their use in the laws of certain States."

* * * * * * *

Legislation which would accomplish many of the President's recommendations has passed both the House and the Senate in differing forms and is now being considered by a conference committee (H.R. 8629 and H.R. 8630).

S. 2304, contrary to the foregoing objective, would establish the Veterans' Administration as a separate agency for supporting the operation of health schools and producing more health professionals when we already are carrying out these purposes in the Department of Health, Education, and Welfare. In the face of a Presidential proposal to consolidate existing grant programs, it would have a contrary result by contributing to their further fragmentation.

We are of the view that the administration of any grant program for these stated purposes should be maintained in the Department of Health, Education, and Welfare.

Accordingly, I recommend against enactment of S. 2304. I believe that legislation more closely implementing the President's program is the proper approach to the expansion of national medical manpower resources.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

DONALD E. JOHNSON,
Administrator.

Vet. Letters 92-29

Executive Office of the President,
Office of Management and Budget,
Washington, D.C., August 17, 1971.

Hon. Vance Hartke,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.

Dear Mr. Chairman: This is in response to your request of July 28, 1971, for the views of this office on S. 2304, and your request of May 19, 1971, for our views on Senate Joint Resolution 76.

S. 2304 is a bill to amend title 38, United States Code, to provide financial assistance to institutions for the establishment and expansion of programs under which veterans with military acquired medical skills will be trained and educated in the allied health professions.

Senate Joint Resolution 76 would amend title 38 of the United States Code to authorize the Administrator of Veterans' Affairs to provide certain assistance in the establishment of new State medical schools affiliated with the Veterans' Administration.

In its reports on S. 2304 and Senate Joint Resolution 76, the Veterans' Administration recommends against their enactment. We concur in the views expressed in those reports, as further explained in our report to your Committee on House Joint Resolution 748, Senate Joint Resolution 128, and S. 2219. Accordingly, we recommend against enactment of S. 2304 and Senate Joint Resolution 76.

Sincerely,

Wilfred H. Rommel,
Assistant Director for Legislative Reference.

92D CONGRESS
1ST SESSION

S. 1635

IN THE SENATE OF THE UNITED STATES

APRIL 22, 1971

Mr. Moss introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

---

A BILL

To amend section 4107 of title 38, United States Code, to provide for the payment of pay differentials for evening, night, weekend, and holiday work performed by nurses employed by the Veterans' Administration, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That subsection (b) of section 4107 of title 38, United States Code, is amended by adding at the end thereof a new paragraph as follows:

"(3) (A) Under regulations prescribed by him, the Administrator shall pay nurses compensated under the nurse schedule in paragraph (1) of this subsection additional compensation, as provided in this paragraph, for duty performed

II

in the evening, at night, on Saturday, Sunday, or on a holiday, and for duty performed in excess of a regular daily or weekly work schedule.

"(B) Any nurse who performs duty on an evening or night tour of duty shall be paid additional compensation for such duty at a rate not exceeding 15 per centum of the hourly rate of pay to which such nurse is entitled.

"(C) Any nurse who performs duty on Saturday shall be paid additional compensation for such duty at a rate not exceeding 20 per centum of the hourly rate of pay to which such nurse is entitled.

"(D) Any nurse who performs duty on Sunday shall be paid additional compensation for such duty at a rate not exceeding 30 per centum of the hourly rate of pay to which such nurse is entitled.

"(E) When any nurse is entitled to additional pay under both subparagraphs (B) and (C) or under both subparagraphs (B) and (D) for the same period of duty, the amounts of such additional compensation shall be computed separately on the basis of the hourly rate of pay to which such nurse is entitled.

"(F) Any nurse who performs duty on a legal public holiday shall be paid additional compensation for such duty (i) at a rate not exceeding 100 per centum of the hourly rate of pay to which such nurse is entitled if such duty is not in excess of such nurse's regularly scheduled duty hours, or (ii) at a rate not exceeding 200 per centum of the hourly rate of pay to which such nurse is entitled if such duty is in excess of such nurse's regularly scheduled duty hours.

"(G) Any nurse who performs duty in excess of the regularly scheduled duty hours during any workday, other than on a legal public holiday, shall be paid additional compensation for such excess duty at a rate not exceeding 150 per centum of the hourly rate of pay to which such nurse is entitled. For purposes of computing the amount of additional compensation to which any nurse is entitled under this subparagraph, the hourly rate of pay of such nurse shall be increased to include the amount by which the hourly rate of pay of such nurse was increased under subparagraphs (B), (C), and (D) for duty performed on the same workday.

"(H) Any nurse who performs duty on six days of any workweek shall be paid additional compensation for the sixth day of such workweek at a rate not exceeding 150 per centum of the hourly rate of pay to which such nurse is entitled, or at a rate not exceeding 200 per centum of such hourly rate if the sixth day of such workweek was a legal public holiday. For purposes of computing the amount of additional compensation to which any nurse is entitled under this subparagraph, the hourly rate of pay of such nurse shall be increased to include the amount by which the hourly rate of pay of such nurse was increased under subparagraph (B) for duty performed on the same workday.

"(I) Any nurse who performs duty on seven days of any workweek shall be paid additional compensation for the seventh day of such workweek at a rate not exceeding 200 per centum of the hourly rate of pay to which such nurse is entitled. For purposes of computing the amount of additional compensation to which any nurse may be entitled under this subparagraph, the hourly rate of pay of such nurse shall be increased to include the amount by which the hourly rate of pay of such nurse was increased under subparagraph (B) for duty performed on the same day.

"(J) When any nurse is entitled to additional compensation under subparagraph (H) or (I), such nurse shall not be entitled to additional compensation under subparagraph (C), (D), or (F) for the same period of duty.

"(K) Any nurse who remains at, or within the confines of, her place of residence in a standby or on-call status (and not in an actual work status) may, under regulations prescribed by the Administrator, be paid additional compensation at a rate not exceeding 25 per centum of the hourly rate of pay to which such nurse is entitled.

"(L) The Administrator shall, on request of any nurse, grant such nurse compensatory time off from such nurse's scheduled tour of duty in lieu of the payment of additional compensation for an equivalent period of time to which such nurse would be entitled under subparagraph (C) (D), (F), (G), (H), or (I).

"(M) Additional compensation paid under this paragraph shall not be considered as basic compensation for the purposes of subchapter VI of chapter 55, chapter 81, 83, or 87 of title 5, United States Code, or other benefits based on basic compensation.

"(N) For purposes of this paragraph, the hourly rate of pay to which any nurse is entitled shall be determined by dividing the annual rate of pay of such nurse by 2080."

Sec. 2. The amendments made by this Act shall become effective on the first day of the second calendar month which begins after the date of enactment of this Act.

[No. 26]

COMMITTEE ON VETERANS' AFFAIRS, UNITED STATES SENATE

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., August 4, 1971.

Hon. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This will respond to your request for a report by the Veterans' Administration on S. 1635, 92d Congress, a bill "To amend section 4107 of title 38, United States Code, to provide for the payment of pay differentials for evening, night, weekend, and holiday work performed by nurses employed by the Veterans' Administration, and for other purposes."

The subject bill would authorize the Administrator to pay nurses compensated under the nurse schedule in section 4107(b)(1) of title 38, for duty performed in the evening, at night, on Saturday, Sunday, or on a holiday, and for duty performed in excess of a regular daily or weekly work schedule.

Any nurse performing duty on an evening or night tour of duty would be paid additional compensation at a rate not exceeding 15 percent of her hourly rate of pay; Saturday, 20 percent; Sunday, 30 percent; legal holiday, 100 percent if not in excess of her regularly scheduled duty hours, or 200 per cent if such duty is in excess of her regularly scheduled duty hours; 150 percent if in excess of her regular duty hours during any workday, other than a legal holiday; 150 percent for duty on the sixth day of any workweek, or 200 percent if the sixth day is a legal holiday; and 200 percent for duty on the seventh day of any workweek. A nurse performing duty on the sixth or seventh day of the workweek would not be entitled to additional compensation for Saturday, Sunday, or holiday duty. Any nurse remaining in her place of residence on standby or oncall status would be paid additional compensation at a rate not exceeding 25 percent of her hourly rate of pay. On request, compensatory time off from the nurse's regular scheduled duty in lieu of additional compensation is authorized.

The bill provides a formula for converting the per annum basic compensation rate into the hourly rate. Such hourly rate would be derived by dividing the annual rate of compensation by 2080, which represents the average number of working hours per year, and is the same formula used in computing the hourly overtime and night rate of pay for civil service employees under title 5, United States Code, where the basic rate of pay of the employee is fixed on an annual basis. Moreover, it provides that "the additional compensation" provided by the bill would not be considered basic compensation for purposes of lump sum leave payments, severance pay, compensation for work injury, retirement, life insurance, or other benefits relating to basic compensation.

Under current law, Veterans' Administration nurses do not receive premium pay for those conditions of work which are generally regarded as more onerous to employees both within and without the Federal Government. A study of hospital practices shows that non-Federal hospitals almost universally provide extra pay for nurses working on evening and night tours of duty. Also, by law, Federal employees under the general schedule, Postal Field Service, and prevailing rate systems of pay are entitled to premium pay for such considerations as Sunday and overtime duty.

The Veterans' Administration has found it very difficult to attract and retain qualified nurses for the evening and night tours of duty in many Veterans' Administration hospitals. An impairment of our ability to provide adequate nursing care for our ill and disabled veteran-patients could result unless immediate action is taken to strengthen our position in this matter.

Developments in recent years with respect to the matter of nurses' pay in private, community and State hospitals throughout the country make it necessary for the Veterans' Administration, which operates the largest single system of medical facilities in the world, to provide a rounded compensation plan for nurses, including customary provisions for premium pay, in order to remain competitive in attracting and retaining highly qualified nursing personnel.

On May 4, 1971, I submitted a draft bill to the President of the Senate, which was subsequently introduced as S. 1924, 92d Congress, and is currently pending before your committee. Section 204 of that bill would provide for a differential pay system for nurses in our Department of Medicine and Surgery, which is predominantly similar to the provisions in other pay systems affecting Federal personnel. Therefore, we urge your committee to give favorable consideration to S. 1924, which contains this and a number of other desirable provisions, in lieu of S. 1635, which we oppose.

It is estimated that enactment of S. 1635 would result in cost of $24.3 million, while section 204 of S. 1924 would cost $16 million for the first fiscal year.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Donald E. Johnson,
Administrator.

Executive Office of the President,
Office of Management and Budget,
Washington, D.C., August 16, 1971.

Hon. Vance Hartke,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.

Dear Chairman: This is in response to your request of May 10, 1971 for the views of this Office on S. 1635, a bill to amend section 4107 of title 38, United States Code, to provide for the payment of pay differentials for evening, night, weekend, and holiday work performed by nurses employed by the Veterans' Administration, and for other purposes.

In its report to your committee on S. 1635, the Veterans' Administration points out that section 204 of S. 1924, which it submitted to the Congress, provides for a differential pay system for nurses in VA's Department of Medicine and Surgery which is predominantly similar to the pay provisions affecting other Federal personnel.

We concur in the recommendation in the report of the Veterans' Administration and, accordingly, favor enactment of S. 1924 in lieu of S. 1635.

Sincerely,

Wilfred H. Rommel,
Assistant Director for Legislative Reference.

92d CONGRESS
1st Session

S. 2340

IN THE SENATE OF THE UNITED STATES

July 23, 1971

Mr. Cranston (for Mr. Montoya and himself) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to create a rebuttable presumption that a disability of a veteran of any war or certain other military service is service-connected under certain circumstances.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 602 of title 38, United States Code, is amended by inserting "(a)" immediately before "For"; and by adding a new subsection as follows:

"(b) For the purposes of this chapter, the disability of any veteran of a war or of service after January 31, 1955, shall be deemed to be service-connected if—

"(1) there are no medical records available to the

II

Veterans' Administration for the period of such veteran's active military, naval, or air service;

"(2) there is no medical record available to the Veterans' Administration for such veteran showing the results of any physical examination which was required by law or regulation, in effect at the time of such veteran's discharge or release from active duty, to be given members of the Armed Forces immediately prior to discharge or release from active duty;

"(3) for any period of time during his active military, naval, or air service such veteran (A) was held as a prisoner of war, or (B) while in line of duty was forceably detained or interned by a foreign government or power;

unless the Administrator can show by clear and convincing evidence that such disability was not incurred in or aggravated in line of duty by such veteran while serving in the active military, naval, or air service."

(b) The catch line of such section is amended to read as follows:

"§ 602. Presumption relating to certain disabilities"

(c) The table of sections at the beginning of chapter 17 of title 38, United States Code, is amended by striking out

"602. Presumption relating to psychosis."

and inserting in lieu thereof

"602. Presumption relating to certain disabilities.".

[No. 28]

COMMITTEE ON VETERANS' AFFAIRS, UNITED STATES SENATE

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., August 4, 1971.

Hon. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request for a report by the Veterans' Administration on S. 2340, 92d Congress, a bill to amend title 38, United States Code, to create a rebuttable presumption that a disability of a veteran of any war or certain other military service is service-connected under certain circumstances.

The bill would amend section 602 of title 38, United States Code, by adding a new subsection to provide for a rebuttable presumption that any disability of a veteran of any war, or of service after January 31, 1955, who is a former prisoner of war or while in the line of duty was forcibly detained or interned by a foreign government or power, is service-connected for the purpose of entitlement to VA hospitalization and outpatient care, including hospital care at VA expense in a foreign country provided pertinent medical records are unavailable.

Under the existing provisions of section 610 of title 38, United States Code, the Administrator, within the limits of Veterans' Administration facilities, may furnish hospital care which he determines is needed to any veteran for a service-connected disability. Hospitalization for a non-service-connected disability, however, may be furnished only if the veteran has wartime service, or service after January 31, 1955, and is unable to defray the expenses of necessary hospital care.

With certain exceptions, not here pertinent, section 612 presently provides that veterans are not eligible for outpatient treatment from the Veterans' Administration for a non-service-connected disorder unless it is associated with and held to be aggravating a service-connected condition.

Statutory presumptions usually presuppose the existence of certain diseases for a period of time before symptoms or clinically demonstrated manifestations appear. A rebuttable presumption of service connection for all disabilities regardless of the nature of their onset or whether from causes occurring after service, as proposed by this legislation, is not medically justifiable. This is also applicable to chronic diseases having an insidious onset as well as to acute conditions of infectious or traumatic origin and chronic disabilities of intercurrent infectious or traumatic origin. The expiration of a period of time, which is usually computed in terms of years, between an experience and the manifestations of symptoms of unknown pathogenesis would ordinarily rebut any concept of etiological relationship.

Making the presumption rebuttable would, therefore, categorically negate the effect of the proposed law where there has been a substantial lapse of time.

The proposed legislation, therefore, presents a policy question as to how far the Government should go in treating a veteran's condition which bears no relation to his service and often occurs years after his discharge from service.

In considering this question, it should be kept in mind that former prisoners of war are now given special consideration under the laws administered by the Veterans' Administration. Our regulations and directives also contain liberal provisions with respect to the claim of any such person for disabilities for the purpose of entitlement to VA benefits including medical benefits. Section 354(a) of title 38, United States Code, requires that in the adjudication of service connection for any disability due consideration will be given to the places, types, and circumstances of service. Section 354(b) provides liberalized criteria for determining service connection of any disease or injury for those veterans who engaged in combat with enemy. Section 612(b)(3) authorizes unlimited outpatient dental services and treatment, and related dental appliances, for any service-connected condition of a veteran who was a prisoner of war.

Veterans' Administration regulations emphasizing the liberality which is accorded in prisoner-of-war cases include, for example, a provision that the development of symptomatic manifestations of a preexisting injury or disease during or closely following a status as a prisoner of war will establish aggravation. Physical examinations of former prisoners of war are conducted with particular thoroughness to discover, if possible, all disabilities common to prisoners of war even where there has been no complaint or prior evidence of such condition. Existing instructions provide that in the evaluation of disabilities resulting from or incident to military service great weight must be assigned to imprisonment or internment under unsanitary conditions or to food deprivation in the service connection of dysentery and other gastrointestinal diseases. All of these considerations permit the Veterans' Administration to reach an equitable decision on the basis of the facts of each individual case, with any reasonable doubt being resolved in favor of the former prisoner of war.

The Veterans' Administration believes that special consideration should be given to former prisoners of war and strives to assure that they receive all benefits in full measure under the law. However, we do not think that former prisoner-of-war status justifies a lifetime of total medical care for conditions having no relation to service. There seems little justification for giving preference solely on this basis when many who underwent comparable privations and hardships, as for example in extended combat, would not be afforded similar consideration.

We are also gravely concerned lest the grant of a rebuttable presumption of service connection for medical benefits would provide a precedent for demands by former prisoners of war or other groups for expansion of the presumption to cover claims for compensation or other benefits.

An extension of medical benefits to former prisoners of war for virtually all disabilities on the basis of a rebuttable presumption would tend to destroy the meaning of the term "service connection." Since its inception, this term has had a special meaning which has rarely been diluted. We strongly recommend against any further inroads on the fixed and accepted concept of service connection.

We estimate the cost of this proposed legislation for former prisoners of war, exclusive of persons presently held as prisoners of the North Vietnamese or listed as missing in action, would be approximately $1,017,000 for fiscal year 1972. Of this, $551,000 may be considered for inpatient care and $466,000 for outpatient care. Similar costs could be experienced for each succeeding 4 fiscal years. The administrative cost would be approximately $215,000 annually.

For the reasons indicated above and since we believe that liberal treatment is already being accorded former prisoners of war under existing laws and procedures, the Veterans' Administration recommends that S. 2340 not be favorably considered by your committee.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Donald E. Johnson,
Administrator.

Vet. Letters 92-28

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, D.C., August 13, 1971.

Hon. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request of July 28, 1971 for the views of this office on S. 2340, a bill to amend title 38, United States Code, to create a rebuttable presumption that a disability of a veteran of any war or certain other military service is service-connected under certain circumstances.

In its report on S. 2340 the Veterans' Administration explains its reasons for recommending that the bill not be favorably considered.

We concur in the views expressed in the report of the Veterans' Administration and, accordingly, oppose enactment of S. 2340.

Sincerely,

WILFRED H. ROMMEL,
Assistant Director for Legislative Reference.

92D CONGRESS
1ST SESSION

H. J. RES. 748

IN THE SENATE OF THE UNITED STATES

JULY 20 (legislative day, JULY 19), 1971

Read twice and referred to the Committee on Veterans' Affairs

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JOINT RESOLUTION

Amending title 38 of the United States Code to authorize the Administrator of Veterans' Affairs to provide certain assistance in the establishment of new State medical schools; the improvement of existing medical schools affiliated with the Veterans' Administration; and to develop cooperative arrangements between institutions of higher education, hospitals, and other public or nonprofit health service institutions, and the Veterans' Administration to develop and conduct educational and training programs for health care personnel.

Whereas there is a great national shortage of physicians and allied health personnel;

Whereas it is now estimated that there is a shortage of approximately 48,000 doctors of medicine and over 250,000 allied health and other medical personnel;

II

Whereas the Veterans' Administration operates the largest medical care system in the United States, if not the world;

Whereas the Department of Medicine and Surgery of the Veterans' Administration has an active and close affiliation with over eighty medical schools;

Whereas if the training of sufficient numbers of physicians, other health professionals, allied health personnel, and other health personnel is to be accomplished, it is essential that the educational capacities of medical and health professions schools affiliated with the Veterans' Administration be expanded, that new medical and health professions schools affiliated with Veterans' Administration hospitals be established, and that education and training opportunities for the training of existing and future allied health and other health personnel be expanded and improved;

Whereas because of the size, diversity, and quality of its medical program, the Veterans' Administration's Department of Medicine and Surgery is uniquely qualified to assist in the expansion and improvement of existing affiliated medical schools and other health professions schools, in the establishment of new medical and health professions schools, and in the expansion and improvement of education and training opportunities for allied health and other health personnel; and

Whereas it is essential that an adequate number of physicians, health professionals, allied health personnel, and other health personnel be trained if the Congress is to discharge its responsibility to provide the best possible medical care for the Nation's veterans: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Veterans' Administration Medical School Assistance and Health Service Personnel Education and Training Act of 1971".

Sec. 2. (a) Part VI of title 38, United States Code, is amended by inserting immediately after chapter 81 the following new chapter—

"Chapter 82.—ASSISTANCE IN ESTABLISHING NEW STATE MEDICAL SCHOOLS; GRANTS TO AFFILIATED MEDICAL SCHOOLS; ASSISTANCE TO HEALTH MANPOWER TRAINING INSTITUTIONS.

"Sec.
"5070. Coordination with public health programs; administration.

"SUBCHAPTER I—PILOT PROGRAM FOR ASSISTANCE IN THE ESTABLISHMENT OF NEW STATE MEDICAL SCHOOLS

"5071. Declaration of purpose.
"5072. Authorization of appropriations.
"5073. Pilot program assistance.
"5074. Limitations.

"SUBCHAPTER II—MATCHING GRANTS TO AFFILIATED MEDICAL SCHOOLS

"5081. Declaration of purpose.
"5082. Authorization of appropriations.
"5083. Grants.
"5084. Payments.
"5085. Limitations.

"SUBCHAPTER III—ASSISTANCE TO PUBLIC AND NONPROFIT INSTITUTIONS OF HIGHER LEARNING, HOSPITALS AND OTHER HEALTH SERVICE INSTITUTIONS AFFILIATED WITH THE VETERANS' ADMINISTRATION TO INCREASE THE PRODUCTION OF PROFESSIONAL AND TECHNICAL ALLIED HEALTH SERVICE PERSONNEL

"5091. Declaration of purpose.
"5092. Definitions.
"5093. Authorization of appropriations.
"5094. Grants.
"5095. Payments.
"5096. Limitations

"§ 5070. Coordination with public health programs; administration

"(a) The Administrator and the Secretary of Health, Education, and Welfare shall, to the maximum extent practicable, coordinate the programs carried out under this chapter and the programs carried out under section 309 and titles VII, VIII, and IX of the Public Health Service Act.

"(b) The Administrator may not enter into any agreement under subchapter I of this chapter or make any grant or other assistance under subchapter II or III of this chapter after December 31, 1978.

"(c) The Administrator shall prescribe regulations covering the terms and conditions for entering into agreements and making grants under this chapter.

"SUBCHAPTER I—PILOT PROGRAM FOR ASSISTANCE IN THE ESTABLISHMENT OF NEW STATE MEDICAL SCHOOLS

"§ 5071. Declaration of purpose

"The purpose of this subchapter is to authorize the Administrator to implement a pilot program under which he may provide assistance in the establishment of new State medical schools if such schools are located in proximity to, and operated in conjunction with, Veterans' Administration medical facilities.

"§ 5072. Authorization of appropriations

"(a) There is hereby authorized to be appropriated $15,000,000 for the fiscal year ending June 30, 1972, and a like sum for each of the six succeeding fiscal years. Sums appropriated pursuant to this section shall be used for making grants to States pursuant to section 5073 (a) (3) of this title.

"(b) Sums appropriated pursuant to subsection (a) of this section shall remain available until the end of the second fiscal year following the fiscal year for which they are appropriated.

"§ 5073. Pilot program assistance

"(a) Subject to subsection (b) of this section the Administrator may enter into an agreement to provide to any State the following assistance to enable such State to establish a new medical school:

"(1) The leasing to the State under such terms and conditions as the Administrator deems appropriate, of such land, buildings, and structures under the control and jurisdiction of the Veterans' Administration as may be necessary for such school. The three-year limitation on the term of a lease in section 5012 (a) of this title shall not apply with respect to any lease entered into pursuant to this paragraph.

"(2) The extension, alteration, remodeling, or repair of buildings and structures provided under paragraph (1) to the extent necessary to make them suitable for use as medical school facilities.

"(3) The payment of grants to reimburse the State for the cost of the salaries of the faculty of such school during the initial twelve-month period of operation of the school and the next six such twelve-month periods, but payment under this paragraph may not exceed an amount equal to—

"(A) 90 per centum of the cost of faculty salaries during the first twelve-month period of operation,

"(B) 90 per centum of such cost during the second such period,

"(C) 90 per centum of such cost during the third such period,

"(D) 80 per centum of such cost during the fourth such period,

"(E) 70 per centum of such cost during the fifth such period,

"(F) 60 per centum of such cost during the sixth such period, and

"(G) 50 per centum of such cost during the seventh such period.

"(b) (1) The Administrator may not enter into any agreement under subsection (a) of this section unless he finds that—

"(A) there will be adequate State financial support for the proposed medical school;

"(B) the overall plans for the school meet such professional and other standards as the Administrator deems appropriate; and

"(C) the school will maintain such arrangements with the Veterans' Administration medical facility with which it is associated (including but not limited to such arrangements as may be made under subchapter IV of chapter 81 of this title) as will be mutually beneficial in the carrying out of the mission of the medical facility and the school.

"(2) Any agreement entered into by the Administrator under this subchapter shall contain such terms and conditions (in addition to those imposed pursuant to subsection (a) (1) of this section) as he deems necessary and appropriate to protect the interest of the United States.

"§ 5074. Limitations

"The Administrator may not use the authority under this subchapter to assist in the establishment of more than five new medical schools. Such schools shall be in geographically dispersed States.

"SUBCHAPTER II—MATCHING GRANTS TO AFFILIATED MEDICAL SCHOOLS

"§ 5081. Declaration of purpose

"The purpose of this subchapter is to authorize the Administrator to carry out a program of grants, on a matching basis, for medical schools which have maintained affiliation with the Veterans' Administration in order to assist such schools to improve and enlarge their facilities.

"§ 5082. Authorization of appropriations

"(a) There is hereby authorized to be appropriated $15,000,000 for the fiscal year ending June 30, 1972, and a like sum for each of the six succeeding fiscal years. Sums appropriated pursuant to this section shall be used for making grants to medical schools pursuant to this subchapter.

"(b) Sums appropriated pursuant to subsection (a) of this section shall remain available until the end of the second fiscal year following the fiscal year for which they are appropriated.

"§ 5083. Grants

"(a) Any medical school which is affiliated with the Veterans' Administration under an agreement entered into pursuant to subchapter IV of chapter 81 of this title may apply to the Administrator for a grant under this subchapter to assist such school, in part, to carry out projects and programs for the improvement and enlargement of its facilities, except that no grant shall be made for the construction of any building which will not be located on land under the jurisdiction of the Administrator. Any such application shall contain such information in such detail as the Administrator deems necessary and appropriate.

"(b) An application for a grant under this section may be approved by the Administrator only upon his determination that—

"(1) the proposed projects and programs for which the grant will be made will make a significant contribution to strengthening the medical education program of the school and will result in a substantial increase in the number of medical students attending such school;

"(2) the application contains or is supported by adequate assurance that any Federal funds made available under this subchapter will be matched by funds or other resources available from other sources, whether public or private;

"(3) the application sets forth such fiscal control and accounting procedures as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this subchapter; and

"(4) the application provides for making such reports, in such form and containing such information, as the Administrator may require to carry out his functions under this subchapter, and for keeping such records and for affording such access thereto as the

Administrator may find necessary or assure the correctness and verification of such reports.

"§ 5084. Payments

"Payments pursuant to grants under this subchapter may be made in installments, and either in advance or by way of reimbursement, with necessary adjustments on account of overpayments or underpayments, as the Administrator may determine.

"§ 5085. Limitations

"A grant to any medical school under this subchapter with respect to any projects or programs approved by the Administrator may not exceed 50 per centum of the total costs, as determined by the Administrator, of such projects and programs.

"SUBCHAPTER III—ASSISTANCE TO PUBLIC AND NONPROFIT INSTITUTIONS OF HIGHER LEARNING, HOSPITALS AND OTHER HEALTH SERVICE INSTITUTIONS AFFILIATED WITH THE VETERANS' ADMINISTRATION TO INCREASE THE PRODUCTION OF PROFESSIONAL AND TECHNICAL ALLIED HEALTH SERVICE PERSONNEL

"§ 5091. Declaration of purpose

"The purpose of this subchapter is to authorize the Administrator to carry out a program of grants, on a matching basis, to provide assistance in the establishment of cooperative arrangements among universities, colleges, junior colleges, community colleges, schools of allied health professions, State and local systems of education, hospitals, and other nonprofit health service institutions, affiliated with the Veterans' Administration, to coordinate and expand the training of professional and technical allied health services personnel; to develop and evaluate new health careers; and to improve allied health manpower utilization.

"§ 5092. Definitions

"For the purpose of this subchapter, the term 'eligible institution' means any educational facility or other public or nonprofit institution, including universities, colleges, junior colleges, community colleges, schools of allied health professions, State and local systems of education, hospitals, and other nonprofit health service institutions for the training or education of allied health or other health personnel affiliated with the Veterans' Administration for the conduct of or the providing of guidance for education and training programs for health manpower.

"§ 5093. Authorization of appropriations

"(a) There is hereby authorized to be appropriated $3,000,000 for the fiscal year ending June 30, 1972, and $4,000,000 for each of the six succeeding fiscal years. Sums appropriated pursuant to this section shall be used for making grants to educational institutions, hospitals, or training establishments pursuant to this subchapter.

"(b) Sums appropriated pursuant to subsection (a) of this section shall remain available until the end of the second fiscal year following the fiscal year for which they are appropriated.

"§ 5094. Grants

"(a) Any eligible institution may apply to the Administrator for a grant under this subchapter to assist such institution to carry out, through the Veterans' Administration hospital with which it is, or will become affiliated educational and clinical projects and programs, matching the clinical requirements of the hospital to the allied health training potential of the eligible institution, for the expansion and improvement of such institution's capacity to train health manpower, including physician's assistants and other new types of health service personnel. Any such application shall contain a plan to carry out such projects and programs and such other information in such detail as the Administrator deems necessary and appropriate.

"(b) An application for a grant under this section may be approved by the Administrator only upon the Administrator's determination that—

"(1) the proposed projects and programs for which the grant will be made will make a significant contribution to improving the education (including continuing education) or training program of the eligible institution and will result in a substantial increase in the number of students trained at such institution;

"(2) the application sets forth such fiscal control and accounting procedures as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this subchapter; and

"(3) the application provides for making such reports, in such form and containing such information, as the Administrator may require to carry out his functions under this subchapter, and for keeping such records and for affording such access thereto as the Administrator may find necessary to assure the correctness and verification of such reports.

"§ 5095. Payments

"Payments made pursuant to grants under this subchapter may be made in installments, and either in advance or by way of reimbursement, with necessary adjustments on account of overpayments or underpayments, as the Administrator may determine.

"§ 5096. Limitations

"A grant to any eligible institution under this subchapter with respect to any projects or programs approved by the Administrator may not exceed 50 per centum of the total costs, as determined by the Administrator, of such projects and programs."

(b) The table of chapters at the beginning of part VI of title 38, United States Code, is amended by adding

"82. Assistance in Establishing New State Medical Schools; Grants to Affiliated Medical Schools; Assistance to Health Manpower Training Institutions.. 5070".

immediately below

"81. Acquisition and Operation of Hospital and Domiciliary Facilities; Procurement and Supply............................ 5001".

Passed the House of Representatives July 19, 1971.

Attest: W. PAT JENNINGS,
Clerk.

EXCERPT FROM H. REPT. 92-322 TO H.J. RES. 748

BACKGROUND OF THE RESOLUTION

The background of this proposal can be summed up best by a paraphrasing of the various whereas clauses which set forth in cogent terms the medical health problem facing the Nation today and the present and potential role which the Veterans' Administration is so uniquely qualified to play in facing up to that problem.

The committee, accordingly, finds that (1) there is a great national shortage of physicians and allied health personnel; (2) it is now estimated that there is a shortage of approximately 48,000 doctors of medicine and over 250,000 allied health and other medical personnel; (3) the Veterans' Administration operates the largest medical care system in the United States, if not the world; (4) the Department of Medicine and Surgery of the Veterans' Administration has an active and close affiliation with over 80 medical schools; (5) if the training of sufficient numbers of physicians, other health professionals, allied health personnel, and other health personnel is to be accomplished, it is essential that the educational capacities of medical and health professions schools affiliated with the Veterans' Administration be expanded, that new medical and health professions schools affiliated with Veterans' Administration hospitals be established, and that education and training opportunities for the training of existing and future allied health and other health personnel be expanded and improved; (6) because of the size, diversity, and quality of its medical program, the Veterans' Administration's Department of Medicine and Surgery is uniquely qualified to assist in the expansion and improvement of existing affiliated medical schools and other health professions schools, in the establishment of new medical and health professions schools, and in the expansion and improvement of education and training opportunities for allied health and other health personnel; and (7) it is essential that an adequate number of physicians, health professionals, allied health personnel, and other health personnel be trained if the Congress is to discharge its responsibility to provide the best possible medical care for the Nation's veterans.

EXPLANATION OF THE RESOLUTION

The resolution provides a new chapter 82 to title 38, United States Code, entitled "Assistance in Establishing New State Medical Schools: Grants to Affiliated Medical Schools; Assistance to Health Manpower Training Institutions." This chapter is divided into three subchapters, each of which is designed to accomplish the following purpose:

Subchapter I.—This subchapter is designed to provide a pilot program for assistance in the establishment of new State medical schools in proximity to, and operated in conjunction with, VA medical facilities. The pilot program would be limited to not more than five new medical schools located in geographically dispersed States. The assistance authorized would include (*a*) leasing to the State of VA land, buildings, et cetera; (*b*) remodeling and repair of VA structures to render them suitable for necessary school facilities; and (*c*) grants (on a reducing scale) to reimburse the State for faculty salaries. The resolution authorizes appropriations of $15 million for fiscal year 1972 and $15 million for each of the next 6 years for the purposes of this subchapter.

Subchapter II.—This subchapter authorizes the Administrator to carry out a program of grants, on a matching basis, for medical schools which have maintained affiliation with the Veterans' Administration in order to assist such schools to carry out projects and programs for the improvement and enlargement of its facilities. In order to control the extent of construction projects the committee has specifically provided that no grant shall be made for the construction of any building which will not be located on land under the jurisdiction of the Administrator. Applications for such grants may be approved by the Administrator only upon his determination that—

(1) the proposed projects and programs for which the grant will be made will make a significant contribution to strengthening the medical education program of the school and will result in a substantial increase in the number of medical students attending such school;

(2) the application contains or is supported by adequate assurance that any Federal funds made available under this subchapter will be matched by funds or other resources available from other sources, whether public or private;

(3) the application sets forth such fiscal control and accounting procedures as may be necessary to assure proper disbursement of and accounting for, Federal funds paid under this subchapter; and

(4) the application provides for making such reports, in such form and containing such information, as the Administrator may require to carry out his functions under this subchapter, and for keeping such records and for affording such access thereto as the Administrator may find necessary or assure the correctness and verification of such reports.

The resolution authorizes appropriations of $15 million for fiscal year 1972 and $15 million for each of the next 6 years for the purposes of this subchapter.

Subchapter III.—The purpose of this subchapter is to authorize the Administrator to carry out a program of grants, on a matching basis, to provide assistance in the establishment of cooperative arrangements among universities, colleges, junior colleges, community colleges, schools of allied health professions, State and local systems of education, hospitals, and other nonprofit health service institutions, affiliated with the Veterans' Administration, to coordinate and expand the training of professional and technical allied health services personnel; to develop and evaluate new health careers; and to improve allied health manpower utilization.

The grants contemplated by this subchapter are designed to assist an institution to carry out, through the Veterans' Administration hospital with which it is, or will become, affiliated, educational and clinical projects and programs, matching the clinical requirements of the hospital to the allied health training potential of the eligible institution, for the expansion and improvement of such institution's capacity to train health manpower, including physician's assistants and other new types of health service personnel.

Applications for such grants may be approved by the Administrator only upon his determination that—

(1) the proposed projects and programs for which the grant will be made will make a significant contribution to improving the education (including continuing education) or training program of the eligible institution and will result in a substantial increase in the number of students trained at such institution;

(2) the application sets forth such fiscal control and accounting procedures as may be necessary to assure proper disbursement of and accounting for Federal funds paid under this subchapter; and

(3) the application provides for making such reports, in such form and containing such information, as the Administrator may require to carry out his functions under this subchapter, and for keeping such records and for affording such access thereto as the Administrator may find necessary to assure the correctness and verification of such reports.

Payments made pursuant to grants under this subchapter may be made in installments, and in advance or by way of reimbursement, with necessary adjustments on account of overpayments or underpayments, as the Administrator may determine.

Appropriations authorized for grants under this subchapter would be in the amount of $3 million for fiscal year 1972 and $4 million for each of the 6 succeeding fiscal years.

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., May 3, 1971.

Hon. OLIN E. TEAGUE,
Chairman, Committee on Veterans' Affairs,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This will respond to your request for a report by the Veterans' Administration on House Joint Resolution 464,[1] 92d Congress, amending title 38 of the United States Code to authorize the Administrator of Veterans' Affairs to provide certain assistance in the establishment of new State medical schools and the improvement of existing medical schools affiliated with the Veterans' Administration.

The stated purpose of the resolution is to expand the health manpower pool of the Nation through the establishment of new medical schools and the improvement of existing medical schools affiliated with Veterans' Administration hospitals, in order to assure an adequate supply of physicians to provide the best possible medical care for veterans.

In order to accomplish the purpose of the resolution, section 1 would add two new subchapters to chapter 81 of title 38, United States Code. Subchapter V would authorize the Administrator to implement a pilot program under which he may provide assistance in the establishment of not more than five new State medical schools if such schools are located in proximity to, and operated in conjunction with, Veterans' Administration medical facilities. This pilot program would permit the Administrator to enter into agreements with not more than five States, geographically dispersed, to assist them in the establishment of new medical schools. This would include—

(1) the leasing to the State under such terms and conditions as the Administrator determines appropriate such excess lands, buildings, and structures under the control of the VA as may be necessary for such a school;

(2) the extension, alteration, and remodeling of buildings and structures to the extent necessary to make them suitable for use as medical school facilities; and,

(3) the payment of grants to reimburse the States for the cost of salaries for the faculty of such schools during the initial 12-month period of operation and for 5 years thereafter. The Federal Government would pay 90 percent of the cost of salaries during the first year, scaled down to 10 percent in the sixth year. To accomplish this $15 million would be authorized to be appropriated for the fiscal year ending June 30, 1971, and a like sum for each of the 6 succeeding fiscal years. The overall plans for the schools would have to meet appropriate professional and other standards as would be mutually beneficial in carrying out the mission of the medical facility and the school and contain such

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[1] H.J. Res. 748 was a clean bill introduced and then reported from the House Veterans Affairs Committee after original consideration of H.J. Res. 464.

other provisions as are necessary to protect the interest of the United States and to accomplish the central purpose of the legislation.

This resolution envisions the use of surplus facilities of the Veterans' Administration in so-called "remote" areas away from the big cities and the establishment of medical schools which would be fully accredited and staffed at the highest professional level. All pilot program agreements entered into under this provision of the resolution would terminate after the close of the seventh calendar year in which subchapter V takes effect.

Subchapter VI would authorize the Administrator to carry out a program of grants, on a matching basis, for medical schools which have maintained affiliation with the Veterans' Administration in order to assist such schools to improve and enlarge their facilities. For this purpose $15 million would be authorized to be appropriated for the fiscal year ending June 30, 1971, and a like sum for each of the 6 succeeding fiscal years. Sums appropriated pursuant to this section would remain available until the end of the second fiscal year following the fiscal year for which they are appropriated. Under this provision of the resolution, grants may be made to any medical school which on the effective date of this subchapter, is affiliated with the Veterans' Administration and applies for a grant to assist such school, in part, to carry out projects and programs for the improvement and enlargement of its facilities.

An application for such a grant may be approved by the Administrator upon determination that (1) the proposed projects and programs for which the grant will be made will make a significant contribution to strengthening the medical education program of the school and will result in a substantial increase in the number of medical students attending such school; (2) the application contains adequate assurance that any Federal funds made available will be matched by funds available from other sources, whether public or private; (3) the application sets forth such fiscal control and accounting procedures as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under the grant. Such grants may not exceed 50 per centum of the total costs of the project and program as determined by the Administrator and may not be made after the close of the seventh calendar year in which the subchapter is enacted.

Section 1 of the resolution authorizes appropriations of $30 million for the fiscal year ending June 30, 1971, and a like sum for each of the 6 succeeding fiscal years. Sums appropriated would remain available until the end of the second fiscal year following the fiscal year for which they are appropriated.

For over 25 years, hospitals of the Veterans' Administration have been offering hospital-based educational experience in collaboration with most of the Nation's medical schools. Veterans' Administration hospitals are currently affiliated with 81 medical schools, 51 dental schools, 287 nursing schools, 274 universities and colleges, and 84 community and junior colleges. During the current fiscal year, more than 50,000 students will participate in more than 60 categories of training in Veterans' Administration institutions. Thus, the Veterans' Administration's contribution in the field of health education has been substantial.

The success and productivity of this partnership between an agency of the Government and the non-Federal system of higher education in the interest of the entire health care system has won the confidence and support of all.

However, we do not feel that the placing of grant authority in the Veterans' Administration for the purposes set forth in section 1 of House Joint Resolution 464 is the proper approach for expanding medical education facilities in the context of the broad national programs for these objectives. This section of House Joint Resolution 464 would duplicate and overlap current authorities under the health professions educational assistance provisions of title VII of the Public Health Service Act to assist in establishment of new schools of medicine, the expansion of existing schools, and the provision of operating support under both formula and special project grants.

The President has emphasized the need for consolidation and coordination of granting mechanisms throughout the Federal Government, stating in his "Health Message" to the Congress on February 18, 1971:

"In addition, I believe that Federal support dollars for the construction of medical education facilities can be used more effectively. I recommend that the five current programs in this area be consolidated into a single, more flexible grant authority and that a new program of guaranteed loans and other financial aids be made available to generate over $500 million in private construction loans in the coming fiscal year—five times the level of our current construction grant program.

"Altogether, these efforts to encourage and facilitate the expansion of our medical schools should produce a 50-percent increase in medical school graduates by 1975. We must set that as our goal and we must see that it is accomplished."

Legislation implementing the President's message (H.R. 5614, 92d Cong.) is currently pending before the House Committee on Interstate and Foreign Commerce.

Section 1 of the resolution, contrary to the foregoing objective, would establish the Veterans' Administration as a separate agency for supporting the construction and operation of medical schools when we already have a bureau for this purpose at the National Institutes of Health. In the face of a Presidential proposal to consolidate existing grant programs, it would, instead, contribute to their further fragmentation.

Accordingly, we are of the view that the administration of any grant program for these stated purposes should be maintained in the Department of Health, Education, and Welfare.

Section 2 of the resolution provides that for a 2-year period immediately following the date of enactment, no part of any real property, under the jurisdiction of the Administrator of Veterans' Affairs, on January 1, 1971, shall be determined to be excess to the needs of the Veterans' Administration, or transferred, or otherwise disposed of, pursuant to any provision of the Federal Property and Administrative Services Act of 1949.

Present Veterans' Administration policy in the review of our real property holdings to determine whether such holdings are excess to our needs, and in our master planning for optimum land use in accordance with long-range plans, includes in the criteria for consideration, possible use for affiliated medical schools or health care training facilities, as well as Veterans' Administration physical facilities, roads and parking, reaction areas, overall esthetics, buffer zones, easement granted to public utility companies, State, or local governments, topography, and cemeteries, to assure that land which is essential to Veterans' Administration activities and responsibilities is not mistakenly declared excess. We feel that this policy assures the maintenance of all Veterans' Administration interests in real property necessary to our long-range planning, and that the provisions of section 2 of the resolution impose an undue and unnecessary limitation on the authority of the executive branch of the Government to dispose of real property excess to the present and future needs of the Federal Government.

Therefore, in view of the foregoing, I recommend against enactment of House Joint Resolution 464. I believe that the President's program, as proposed in H.R. 5614, is the proper approach to expansion of national medical manpower resources.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report to your committee, and that enactment of H.R. 5614 would be in accord with the program of the President.

Sincerely,

DONALD E. JOHNSON, *Administrator.*

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, D.C., May 3, 1971.

Hon. OLIN E. TEAGUE,
Chairman, Committee on Veterans' Affairs, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request of March 23, 1971, for the views of this office on House Joint Resolution 464, a resolution amending title 38 of the United States Code to authorize the Administrator of Veterans' Affairs to provide certain assistance in the establishment of new State medical schools and the improvement of existing medical schools affiliated with the Veterans' Administration.

In its report on House Joint Resolution 464, the Veterans' Administration recommends against the enactment of the resolution and indicates that the Administration has submitted comprehensive medical manpower proposals. These proposals are contained in H.R. 5614, the Health Manpower Assistance Act of 1971, and would implement recommendations contained in the President's health message of February 18, 1971.

The Veterans' Administration also points out that the grant authorizations contained in House Joint Resolution 464 would duplicate and overlap existing authorities in the Public Health Service Act under which the Department of Health, Education, and Welfare provides grant assistance to new and existing schools of medicine.

With respect to section 2 of House Joint Resolution 464, the Veterans' Administration indicates that it would "impose an undue and unnecessary limitation on the authority of the executive branch of the Government to dispose of real property excess to the present and future needs of the Federal Government."

We concur in the comments of the Veterans' Administration. Accordingly, we strongly recommend against enactment of House Joint Resolution 464. We believe the proposals in H.R. 5614 constitute a comprehensive approach to meeting the Nation's manpower requirements.

Sincerely,

WILFRED H. ROMMEL,
Assistant Director for Legislative Reference.

[No. 24]

COMMITTEE ON VETERANS' AFFAIRS, UNITED STATES SENATE

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., August 4, 1971.

Hon. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This will respond to your request for a report on H.J. Res. 748, 92d Congress, the "Veterans' Administration Medical School Assistance and Health Service Personnel Education and Training Act of 1971."

The stated purpose of H.J. Res. 748 is to expand the health manpower pool of the Nation through the establishment of new medical schools and the improvement of existing medical and health professions schools affiliated with Veterans' Administration hospitals, in order to assure an adequate supply of physicians, health professionals, allied health personnel, and other health personnel to provide the best possible medical care for veterans.

The resolution would add a new chapter 82 to title 38, United States Code, containing three new subchapters.

Subchapter I would authorize the Administrator to implement a pilot program under which he may provide assistance in the establistment of not more than five new State medical schools if such schools are located in proximity to, and operated in conjunction with, Veterans' Administration medical facilities. This pilot program would permit the Administrator to enter into agreements with not more than five States, geographically dispersed, to assist them in the establishment of new medical schools. This would include:

(1) the leasing to the State under such terms and conditions as the Administrator determines appropriate such excess lands, buildings, and structures under the control of the VA as may be necessary for such a school;

(2) the extension, alteration, and remodeling of buildings and structures to the extent necessary to make them suitable for use as medical school facilities; and

(3) the payment of grants to reimburse the States for the cost of salaries for the faculty of such schools during the initial 12-month period of operation and for 6 years thereafter. The Federal Government would pay 90 percent of the cost of salaries during the first 3 years, scaled down from 80 percent during the fourth year to 50 percent in the seventh year. To accomplish this, $15 million would be authorized to be appropriated for the fiscal year ending June 30, 1972, and a like sum for each of the 6 succeeding fiscal years. The overall plans for the schools would have to meet appropriate professional and other standards as would be mutually beneficial in carrying out the mission of the medical

facility and the school and contain such other provisions as are necessary to protect the interest of the United States and to accomplish the central purpose of the legislation.

This resolution envisions the use of surplus facilities of the Veterans' Administration in so-called remote areas away from the big cities and the establishment of medical schools which would be fully accredited and staffed at the highest professional level.

Subchapter II would authorize the Administrator to carry out a program of grants, on a matching basis, for medical schools which have maintained affiliation with the Veterans' Administration in order to assist such schools to improve and enlarge their facilities. For this purpose $15 million would be authorized to be appropriated for the fiscal year ending June 30, 1972, and a like sum for each of the 6 succeeding fiscal years. Under this provision of the resolution, grants may be made to any medical school which is affiliated with the Veterans' Administration and applies for a grant to assist such school, in part, to carry out projects and programs for the improvement and enlargement of its facilities.

An application for such a grant may be approved by the Administrator upon determination that (1) the proposed projects and programs for which the grant will be made will make a significant contribution to strengthening the medical education program of the school and will result in a substantial increase in the number of medical students attending such school; (2) the application contains adequate assurance that any Federal funds made available will be matched by funds available from other sources, whether public or private; (3) the application sets forth such fiscal control and accounting procedures as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under the grant. Such grants may not exceed 50 percent of the total costs of the project and program as determined by the Administrator.

Subchapter III would authorize the Administrator to carry out a program of grants, on a matching basis, to provide assistance in the establishment of cooperative arrangements among universities, colleges, junior colleges, community colleges, schools of allied health professions, State and local systems of education, hospitals, and other nonprofit service institutions, affiliated with the Veterans' Administration, to coordinate and expand the training of professional and technical allied health services personnel; to develop and evaluate new health careers, and to improve allied health manpower utilization. For this purpose, $3 million for the fiscal year ending June 30, 1972, and $4 million for each of the 6 succeeding fiscal years would be authorized.

An application from an eligible institution for a grant may be approved by the Administrator upon his determination that: (1) the proposed projects and programs will make a substantial increase in the number of students trained at such institution; (2) the application sets forth necessary fiscal control and accounting procedures; and (3) the application provides for making such reports, keeping such records, and providing access thereto as the Administrator shall require. Such grants may not exceed 50 percent of the total costs of such projects and programs as determined by the Administrator.

Appropriations in a total sum of $33 million would be authorized for the fiscal year ending June 30, 1972, and $34 million for each of the 6 succeeding fiscal years. Sums appropriated would remain available until the end of the second fiscal year following the fiscal year for which they are appropriated.

For over 25 years, hospitals of the Veterans' Administration have been offering hospital-based educational experience in collaboration with most of the Nation's medical schools. Veterans' Administration hospitals are currently affiliated with 81 medical schools, 51 dental schools, 287 nursing schools, 274 universities and colleges and 84 community and junior colleges. During the current fiscal year, more than 50,000 students will participate in more than 60 categories of training in Veterans' Administration institutions. Thus, the Veterans' Administration's contribution in the field of health education has been substantial.

The success and productivity of this partnership between an agency of the Government and the non-Federal system of higher education in the interest of the entire health care system has won the confidence and support of all.

However, we do not feel that the placing of grant authority in the Veterans' Administration for the purposes set forth in H.J. Res. 748 is the proper approach for expanding medical education facilities in the context of the broad national programs for these objectives. The subject resolution would duplicate and overlap current authorities under the Health Professions Educational Assistance provisions of titles VII and VIII of the Public Health Service Act to asist in the establishment of new schools of medicine, the expansion of existing schools, the provision of operating support under both formula and special project grants, and the training of health service personnel.

The President has emphasized the need for consolidation and coordination of granting mechanisms throughout the Federal Government, stating in his "Health Message" to the Congress on February 18, 1971:

> "In addition, I believe that Federal support dollars for the construction of medical education facilities can be used more effectively. I recommend that the five current programs in this area be consolidated into a single, more flexible grant authority and that a new program of guaranteed loans and other financial aids be made available to generate over $500 million in private construction loans in the coming fiscal year—five times the level of our current construction grant program.
>
> "Altogether, these efforts to encourage and facilitate the expansion of our medical schools should produce a 50-percent increase in medical school graduates by 1975. We must set that as our goal and we must see that it is accomplished.
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> * * * * * * *
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> "I recommend that our allied health personnel training programs be expanded by 50 percent over 1971 levels, to $29 million, and that $15 million of this amount be devoted to training physicians' assistants. We will also encourage medical schools to train future doctors in the proper use of such assistants and we will take the steps I described earlier to eliminate barriers to their use in the laws of certain States."

Legislation which would accomplish many of the President's recommendations has passed both the House and the Senate in differing forms and is now being considered by a conference committee (H.R. 8629 and H.R. 8630).

The subject resolution, contrary to the foregoing objective, would establish the Veterans' Administration as a separate agency for supporting the construction and operation of medical schools and producing more health professionals when we already are carrying out these purposes in the Department of Health, Education, and Welfare. In the face of a Presidential proposal to consolidate existing grant programs, it would have a contrary result by contributing to their further fragmentation.

We are of the view that the administration of any grant program for these stated purposes should be maintained in the Department of Health, Education, and Welfare.

Accordingly, I strongly oppose enactment of H.J. Res. 748. I believe that legislation more closely implementing the President's program is the proper approach to the expansion of national medical manpower resources.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

DONALD E. JOHNSON,
Administrator.

Department of Health, Education, and Welfare,
Washington, D.C., August 13, 1971.

Hon. Vance Hartke,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.

Dear Mr. Chairman: There is now pending before your committee a joint resolution, House Joint Resolution 748, as passed by the House of Representatives, amending title 38 of the United States Code to authorize the Administrator of Veterans' Affairs to provide certain assistance in the establishment of new State medical schools; the improvement of existing medical schools affiliated with the Veterans' Administration; and to develop cooperative arrangements between institutions of higher education, hospitals, and other public or nonprofit health service institutions, and the Veterans' Administration to develop and conduct educational and training programs for health care personnel, on which we would like to submit the Department's comments.

The resolution would add a new chapter 82 to title 38, United States Code.

Subchapter I would authorize the Veterans' Administration to assist in the establishment of new State medical schools located in proximity to, and in conjunction with, Veterans' Administration medical facilities. Such assistance would be limited to no more than five medical schools located in geographically dispersed States.

Appropriations of $15 million for each of the 7 fiscal years 1972 through 1978 would be authorized for this new program.

Subchapter II of the new chapter 82 would authorize the Administrator of Veterans' Affairs to make matching grants to medical schools—public or private—which are affiliated with Veterans' Administration medical facilities to assist such schools in projects and programs for improvement and enlargement of their facilities.

For these grants, the resolution would authorize appropriations of $15 million for each of 7 fiscal years, 1972 through 1978.

Subchapters I and II of the resolution would duplicate and overlap the authorities of this Department under the health professions educational assistance provisions of title VII of the Public Health Service Act to assist in the establishment of new schools of medicine, the expansion of existing schools, and the provision of operating support under both formula and special project grants.

Legislation to extend and significantly modify these authorities has passed both the House and the Senate and is now before a conference committee. This legislation is designed to stimulate increases in enrollments in schools of medicine, provide substantially increased support of operating programs of such schools, give special assistance to establishment of new schools, and stimulate cooperative arrangements among medical schools and health service institutions.

The proposed legislation before the conferees would substantially increase assistance in the establishment and maintenance of schools of medicine and heighten the relationship of new as well as established schools with a wide variety of health service institutions. It includes provisions for assistance to schools of medicine for construction of teaching facilities, including affiliated hospitals, institutional assistance in the form of capitation grants for faculty and other operating costs, and several provisions for grants for assistance for the establishment and operation of new schools, public or private.

We are in accord with the objective of the resolution to encourage the Veterans' Administration to take a more active role in cooperating with medical schools for the planning and maintenance of those portions of clinical experience that can contribute most appropriately to teaching programs. However, we strongly oppose the duplication and fragmentation of programs within the Federal Government for assistance in the establishment, support, or expansion of medical schools. Nor can we justify preferential and disproportionate Federal support of a few selected State medical schools over that of other developing or proposed State or private medical schools which would be assisted under the health professions provisions now before the conferees. Moreover, we seriously question the proposal under the resolution to provide such a high Federal percentage of total faculty costs—90 percent during the first 3 years of operation; 80 percent the fourth year; 70 percent the fifth year; 60 percent the sixth; and 50 percent the seventh. It is particularly important that institutions as complex as medical schools be initiated and developed with sufficient non-Federal support to evidence a bona fide commitment to sound establishment and continuing operations.

For over 25 years, hospitals of the Veterans' Administration have been offering hospital-based educational experience in collaboration with the Nation's medical schools. The Veterans' Administration has made and is making significant contributions in the field of medical education. However, we do not feel that authorizing the Veterans' Administration to make grants for the purposes set forth in subchapters I and II of the resolution is the appropriate Federal mechanism for the construction and expansion of medical education facilities or for assistance in the operation of medical school teaching programs.

Subchapter III of the resolution would authorize the Administrator to make matching grants to a variety of public and other nonprofit educational and health service institutions and agencies, which are affiliated with the Veterans' Administration and which provide training or education of allied health or other health personnel to coordinate and expand the training of professional and technical allied health services personnel, to develop and evaluate new health careers, and to improve allied health manpower utilization.

Grants under this subchapter would be used to assist an institution to carry out, through the Veterans' Administration hospital with which it is, or will become, affiliated, educational or clinical projects and programs, matching the clinical requirements of the hospital to the allied health training potential of the eligible institution, for the expansion and improvement of such institution's capacity to train health manpower, including physicians' assistants and other new types of health service personnel.

Subchapter III of the resolution would duplicate the allied health training authorities of part G of title VII of the Public Health Service Act—authorities which were significantly broadened and extended last year (Public Law 91–519) to authorize grants to public and other nonprofit agencies, organizations, and institutions, and to schools of the allied health professions, to expand the training of professional and technical allied health personnel, to develop, demonstrate, and evaluate new types of health manpower, and to improve utilization of allied health manpower.

This authority specifically covers project grants or contracts to develop, demonstrate, or establish interrelationships among educational and service institutions which will facilitate the training, retraining, or utilization of allied health manpower.

Part G also includes authority for construction of teaching facilities for allied health training centers, grants for operation of training programs directed toward the expansion or improvement of such programs, grants for the planning, establishing, demonstrating, or developing new programs, or the modification or expansion of existing programs, including interdisciplinary training programs.

The proposed health professions legislation now before the conferees also includes authority for assistance to schools of the health professions and other health and educational entities—both educational and service—for projects for the training of physicians' assistants, development and evaluation of new types of health careers, and improved health manpower utilization.

Among the major purposes of this authority is the establishment of cooperative arrangements among educational institutions—universities, colleges, and so forth—and hospitals and other health service institutions, to the end that there will be an increased relevance between education and service, and more appropriate geographic distribution of health manpower training endeavors.

The resolution requires the Administrator of Veterans' Affairs and the Secretary of Health, Education, and Welfare to coordinate, to the maximum extent practicable, the programs carried out under these three subchapters with programs carried out under section 309 (public health), title VII (health professions and allied health authorities), title VIII (nurse training), and title IX (regional medical programs) of the Public Health Service Act. This provision, however, is not sufficient to compensate for the undesirable duplication of our authority which the resolution would authorize. We believe that the preferred approach is to avoid a Veterans' Administration program duplicating the more general program administered by this Department.

For the foregoing reasons, we recommend against favorable action on House Joint Resolution 748.

We are advised by the Office of Management and Budget that there is no objection to the presentation of these comments from the standpoint of the Administration's program.

Sincerely,

John G. Veneman,
Acting Secretary.

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, D.C., August 17, 1971.

Hon. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs,
Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your requests for the views of this office on House Joint Resolution 748 and Senate Joint Resolution 128 (July 28, 1971), and S. 2219 (July 2, 1971).

The indicated purpose of these legislative proposals is to expand the health manpower pool of the Nation primarily by authorizing the Veterans' Administration to make grants for (1) assisting affiliated medical schools and establishing new medical schools and (2) training of various types of health personnel, including health paraprofessionals.

In its reports to the committee on these proposals, the Veterans' Administration strongly opposes their enactment. The VA points out that the grants which they would authorize would duplicate and overlap existing authorities under which the Department of Health, Education, and Welfare provides grant assistance to new and existing schools of medicine and assists in the training of allied health professionals.

The VA also points out that the President's health message to the Congress of February 18, 1971, included recommendations dealing with the Nation's health manpower needs. Those recommendations approach the problem of health manpower supply in a comprehensive manner, whereas the proposals covered by this report would have the contrary result of further fragmentation of effort.

We note, further, that S. 2219 contains a section that would prohibit, for a 2-year period, any real property under the jurisdiction of the VA from being determined to be excess to the needs of the VA or transferred or otherwise disposed of under the Federal Property and Administrative Services Act of 1949. In its report, the VA indicates that the provisions of this section "impose an undue and unnecessary limitation on the authority of the Executive branch of the Government to dispose of real property excess to the present and future needs of the Federal Government."

We concur in the views expressed in the reports of the VA and, accordingly, strongly oppose enactment of House Joint Resolution 748, Senate Joint Resolution 128, and S. 2219.

Sincerely,

WILFRED H. ROMMEL,
Assistant Director for Legislative Reference.

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C., October 1, 1971.

Hon. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: Reference is made to your letter of September 14, 1971, requesting our comments on House Joint Resolution 748.

The purpose of the bill is to amend title 38 of the United States Code to authorize the Administrator of Veterans' Affairs to (1) provide assistance in the establishment of new State medical schools, (2) provide assistance in the improvement of existing medical schools affiliated with the Veterans' Administration (VA) and; (3) develop cooperative arrangements between institutions of higher education, hospitals, and other public or nonprofit health service institutions, and VA to develop and conduct educational and training programs for health care personnel.

The stated purpose of subchapter II of the bill is to authorize VA to carry out a program of grants, on a matching basis, for medical schools which have maintained affiliations with VA in order to assist such schools to improve and enlarge their facilities. However, under the proposed section 5083(a) it appears that only those medical schools which have entered into agreements with VA for the sharing of medical facilities, equipment, and information under subchapter IV of chapter 81, title 38 (38 U.S.C. 5051-5057), are eligible to receive such grants. There are presently about 80 schools that are affiliated with VA hospitals for education and training purposes; however, only about 16 of these affiliated medical schools have entered into agreements with VA for the sharing of medical facilities, equipment, and information pursuant to 38 United States Code 5051 et seq. Because the proposed restriction on eligibility of medical schools for grants appears inconsistent with the purpose of subchapter II of the bill, your Committee may wish to consider making all medical schools affiliated with VA eligible for grants so that VA can have a wider choice in selecting those schools which it will aid in improving and enlarging facilities.

Proposed section 5083(a) provides that any medical school which is affiliated with VA pursuant to an agreement for the sharing of medical facilities, equipment, and information (38 U.S.C. 5051–5057) may apply to VA for a grant to assist such school, in part, to carry out projects and programs for the improvement and enlargement of its facilities except that no grant shall be made for the construction of any building which will not be located on land under the jurisdiction of the Administrator. It is apparent that facilities built pursuant to this section must be located on VA land. However, because section 5083(b)(2) requires that Federal grants must be matched by funds or resources from public or private sources, the committee may wish to consider further clarification as to whether VA or the medical school will retain title to facilities financed, in part, by VA grants pursuant to this section.

Sections 5083(b)(4) and 5094(b)(3) require that applications for grants under this bill may be approved by VA only if the grantee's application provides for the making of such reports as required by the Administrator and for keeping records and affording VA access to these records to assure the correctness and verification of such reports. We believe the Comptroller General also should be given specific authority to have access to the records maintained by grantees pursuant to these sections of the bill. Accordingly, we suggest that a new paragraph (c) be added to sections 5083 and 5094 to read as follows:

"(c) The Comptroller General of the United States, or any of his duly authorized representatives, shall have access for the purpose of audit and examination to the records specified in paragraph (b) of this section."

Sincerely yours,

PAUL G. DEMBLING,
Acting Comptroller General of the United States.

92D CONGRESS
1ST SESSION

H. R. 481

IN THE SENATE OF THE UNITED STATES

MARCH 2 (legislative day, FEBRUARY 17), 1971
Read twice and referred to the Committee on Veterans' Affairs

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AN ACT

To provide for the adjustment by the Administrator of Veterans' Affairs, of the legislative jurisdiction over lands belonging to the United States which are under his supervision and control.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) subchapter I of chapter 81 of title 38, United States Code, is amended by adding at the end thereof the following new section:

"§ 5007. Relinquishment of legislative jurisdiction

"The Administrator, on behalf of the United States, may relinquish to the State in which any lands or interests therein under his supervision or control are situated, such

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measure of legislative jurisdiction over such lands or interests as he deems necessary or desirable. Such relinquishment of legislative jurisdiction shall be initiated by filing a notice thereof with the Governor of the State concerned, or in such other manner as may be prescribed by the laws of such State, and shall take effect upon acceptance by such State."

(b) The table of sections at the beginning of chapter 81 of title 38, United States Code, is amended by adding after

"5006. Property formerly owned by National Home for Disabled Volunteer Soldiers."

the following:

"5007. Relinquishment of legislative jurisdiction."

Passed the House of Representatives March 1, 1971.

Attest: W. PAT JENNINGS,
Clerk.

[No. 11]

COMMITTEE ON VETERANS' AFFAIRS, UNITED STATES SENATE

Veterans' Administration,
Office of the Administrator of Veterans' Affairs,
Washington, D.C., May 7, 1971.

Hon. Vance Hartke,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.

Dear Mr. Chairman: This will respond to your request for a report by the Veterans' Administration on H.R. 481, 92d Congress, an act "To provide for the adjustment by the Administrator of Veterans' Affairs, of the legislative jurisdiction over lands belonging to the United States which are under his supervision and control."

The bill would authorize the Administrator of Veterans' Affairs, with respect to Federal lands under his jurisdiction, to relinquish to a State in which the land is situated such measure of legislative jurisdiction as he deems desirable. The relinquishment of jurisdiction would be subject to acceptance by the State.

H.R. 481 is identical to a draft bill which was transmitted by the Veterans' Administration to the President of the Senate by letter dated July 29, 1969, a copy of which is enclosed for your ready reference. The reasons stated in our transmittal letter in support of the measure proposed in 1969 are equally applicable to H.R. 481.

The United States has exclusive legislative jurisdiction over a substantial portion of the Federal lands under the jurisdiction and control of the Veterans' Administration. This exclusive legislative jurisdiction, has on occasion, created problems in obtaining certain services adjunct to the operation of our hospitals and centers. Local authorities have furnished various services such as police assistance, commitment of patients and inquests, even though there has been doubt expressed as to their authority.

The Congress, in considering the Military Construction Authorization Act of 1971 (Public Law 91-511), extended to the military departments authority to relinquish to a State all or such portion of the legislative jurisdiction previously acquired by the United States over lands or interests therein under their custody and control as the department head concerned may deem desirable. H.R. 481 would extend the same authority to the Administrator of Veterans' Affairs.

The bill would obviate the need for coming to the Congress each time a jurisdictional problem arises at a particular station, which has been necessary in the past. Such relinquishment of jurisdiction as might be granted if this legislation is enacted will not, of course, permit any State to interfere with any Federal function.

For the foregoing reasons, we recommend favorable consideration of H.R. 481, enactment of which would entail little, if any, cost to the Government.

In connection with a similar report to the Chairman, House Committee on Veterans' Affairs, we were advised by the Office of Management and Budget that there was no objection from the standpoint of the Administration's program to the presentation of that report to that committee.

Sincerely,

Donald E. Johnson,
Administrator.

Veterans' Administration,
Office of the Administrator of Veterans' Affairs,
Washington, D.C., July 29, 1971.

Hon. Spiro T. Agnew,
President of the Senate,
Washington, D.C.

Dear Mr. President: Transmitted herewith is a draft bill "To provide for the adjustment, by the Administrator of Veterans' Affairs, of the legislative jurisdiction over lands belonging to the United States which are under his supervision and control." We request that it be introduced and considered for enactment.

The bill would authorize the Administrator of Veterans' Affairs, with respect to Federal lands under his jurisdiction, to relinquish to a State in which the land is situated such measure of legislative jurisdiction as he deems desirable. The relinquishment of jurisdiction would be subject to acceptance by the State.

The United States has exclusive legislative jurisdiction over a substantial portion of the Federal lands under the jurisdiction and control of the Veterans' Administration. This exclusive legislative jurisdiction has, on occasion, created problems in obtaining certain services adjunct to the operation of our hospitals and centers. Representative of such a problem is the situation at our Center, Fort Harrison, Mont. There is one resident Federal Bureau of Investigation agent in Helena, about 4 miles away, and the nearest U.S. Marshal headquarters is about 70 miles distant in Butte. Local authorities have furnished various services, such as police assistance, commitment of patients, and inquests, even though there has been doubt expressed as to their authority.

The Veterans' Administration presently has no general authority to adjust the legislative jurisdiction of Federal property under its control. Accordingly, to overcome the problems at this particular reservation, we submitted to the Congress a proposal to cede to the State of Montana concurrent jurisdiction with the United States. The proposal, H.R. 3689, was favorably considered by the Congress and, upon approval by the President on July 19, 1969, became Public Law 91-45.

In order to obviate the need for coming to the Congress each time a problem of this nature arises, we seek enactment of this legislation granting the Administrator general authority to relinquish legislative jurisdiction to the State in which the land is situated. Such relinquishment of jurisdiction, of course, will not permit the States to interfere with any Federal function.

For the reasons set forth above, we recommend favorable consideration of the proposal, enactment of which would entail little, if any, cost to the Federal Government.

Advice was received from the Bureau of the Budget in a letter dated July 11, 1969, that there would be no objection to the presentation of the proposed legislation from the standpoint of the administration's program.

Sincerely,

Donald E. Johnson,
Administrator.

Enclosure.

A BILL To provide for the adjustment, by the Administrator of Veterans' Affairs, of the legislative jurisdiction over lands belonging to the United States which are under his supervision and control.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) subchapter I of chapter 81 of title 38, United States Code, is amended by adding at the end thereof the following new section:

"§ *5007. Relinquishment of legislative jurisdiction*

"The Administrator, on behalf of the United States, may relinquish to the State in which any lands or interests therein under his supervision or control are situated, such measure of legislative jurisdiction over such lands or interests as he deems necessary or desirable. Such relinquishment of legislative jurisdiction shall be initiated by filing a notice thereof with the Governor of the State concerned, or in such other manner as may be prescribed by the laws of such State, and shall take effect upon acceptance by such State."

(b) The table of sections at the beginning of chapter 81 of title 38, United States Code, is amended by adding after "5006. Property formerly owned by National Home for Disabled Volunteer Soldiers.", the following:

"5007. Relinquishment of legislative jurisdiction."

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, D.C., August 26, 1971.

Hon. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs,
U.S. Senate,
Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request of August 16, 1971, for the views of the Office of Management and Budget on H.R. 481, an act to provide for the adjustment by the Administrator of Veterans' Affairs, of the legislative jurisdiction over lands belonging to the United States which are under his supervision and control, which was passed by the House of Representatives on March 1, 1971.

For the reasons expressed by the Veterans' Administration in its testimony before your committee on August 4, 1971, and in its report to the House Committee on Veterans' Affairs dated February 9, 1971, we recommend enactment of H.R. 481.

Sincerely,

WILFRED H. ROMMEL,
Assistant Director for Legislative Reference.

Senator CRANSTON. Our first witness was to have been Mr. Fred Rhodes, Deputy Administrator of Veterans' Affairs, Veterans' Administration, accompanied by Dr. Marc Musser, chief medical director, Veterans' Administration. I do not, however believe Mr. Rhodes is with us.

STATEMENT OF DR. MARC J. MUSSER, MEDICAL DIRECTOR, VETERANS' ADMINISTRATION, ACCOMPANIED BY DR. BENJAMIN B. WELLS, DEPUTY MEDICAL DIRECTOR, JOHN CORCORAN, GENERAL COUNSEL, AND JAMES LUND, OFFICE OF ASSISTANT ADMINISTRATOR FOR PERSONNEL

Dr. MUSSER. Mr. Rhodes is out of the city and cannot be present. With your permission I will present our statement. I would like to say first, that I appreciate your understanding of the situation and your comments.

Senator CRANSTON. Would you introduce the others with you?

Dr. MUSSER. On my right is Mr. John Corcoran, our general counsel. On my left is Dr. Benjamin B. Wells, deputy chief medical director. To his left is Mr. James Lund from the Office of the Assistant Administrator for Personnel. Also in the audience is Mr. Viggio Miller, our assistant administrator for construction.

Mr. Chairman, I would like to thank you for affording me this opportunity to appear before you and present the views of the Veterans' Administration relative to the several bills now before you for consideration.

I would like initially to state that we are furnishing the chairman of the full committee with reports on all the measures under consideration. These reports contain our detailed analysis and views on each measure and the cost thereof. I will, therefore, limit my testimony to a general discussion of several of the more important aspects of the legislation now before you.

The first of these bills which I will discuss is House Joint Resolution 748 which would expand the health manpower pool of the Nation through the establishment of new medical schools and the improvement of existing medical and health professions schools affiliated with Veterans' Administration hospitals, in order to assure an adequate supply of physicians, health professionals, allied health personnel, and other health personnel to provide the best possible medical care for veterans.

It would add a new chapter 82 to title 38, United States Code, containing three new subchapters.

Subchapter I would authorize the Administrator to implement a pilot program under which he may provide assistance in the establishment of not more than five new State medical schools if such schools are located in proximity to, and operated in conjunction with, Veterans' Administration medical facilities.

Subchapter II would authorize the Administrator to carry out a program of grants, on a matching basis, for medical schools which have maintained affiliation with the Veterans' Administration in order to assist such schools to improve and enlarge their facilities. For this purpose, $15 million would be authorized to be appropriated for the fiscal year ending June 30, 1972, and a like sum for each of the 6 succeeding fiscal years.

For over 25 years, hospitals of the Veterans' Administration have been offering hospital-based educational experience in collaboration with most of the Nation's medical needs. Veterans' Administration hospitals are currently affiliated with 81 medical schools, 51 dental schools, 287 nursing schools, 274 universities and colleges and 84 community and junior colleges. During the current fiscal year, more than 50,000 students will participate in more than 60 categories of training in Veterans' Administration institutions. Thus, the Veterans' Administration's contribution in the field of health education has been substantial.

The success and productivity of this partnership between an agency of the Government and the non-Federal system of higher education in the interest of the entire health care system has won the confidence and support of all. However, we do not feel that the placing of grant authority in the Veterans' Administration for the purposes set forth in House Joint Resolution 748 is the proper approach for expanding medical education facilities to meet the broad national needs. Instead, it would duplicate and overlap current authorities under the Health Professions Educational Assistance provisions of titles VII and VIII of the Public Health Service Act to assist in the establishment of new schools of medicine, the expansion of existing schools, the provision of operating support under both formula and special project grants, and the training of health service personnel.

We feel that the enactment of this legislation would contribute to a fragmentation of authority at a time when the President has emphasized the need for consolidation and coordination of granting mechanisms throughout the Federal Government. Legislation to accomplish this objective, as spelled out in the President's "Health Message" to the Congress on February 18, 1971, is presently pending before the Congress. Accordingly, the VA is strongly opposed to the enactment of House Joint Resolution 748.

Senate Joint Resolution 128, except for the title, is identical to House Joint Resolution 748, and my foregoing remarks are equally applicable thereto.

Senate Joint Resolution 76, while not identical to House Joint Resolution 748, has the same purpose, and S. 2304, although limited in scope to education opportunities for veterans, would, in general, accomplish a similar objective through grant programs. However, section 2 of Senate Joint Resolution 76 provides that for a 2-year period immediately following the date of enactment, no part of any real property, under the jurisdiction of the Administrator of Veterans Affairs, on January 1, 1971, shall be determined to be excess to the needs of the Veterans' Administration, or transferred, or otherwise disposed of, pursuant to any provision of the Federal Property and Administrative Services Act of 1949.

Present Veterans' Administration policy is to review our real needs, and in our master planning for optimum land use in accordance with long-range plans, include in the critera for consideration, possible use for affiliated medical schools or health care training facilities, as well as Veterans' Administration physical facilities, roads and parking, recreation areas, overall esthetics, buffer zones, easement granted to public utility companies, State, or local governments, topography, and cemeteries, to assure that land which is essential to Veterans' Administration activities and responsibilities is not mistakenly declared excess. We feel that this policy assures the maintenance of all Veterans' Administration interests in real property necessary to our long-range planning, and that the provisions of section two of the resolution impose an undue and unnecessary limitation on the authority of the executive branch of the Government to dispose of real property excess to the present and future needs of the Federal Government.

My views with respect to House Joint Resolution 748 are equally applicable to Senate Joint Resolution 76 and S. 2304, and I would recommend against their favorable consideration.

S. 2219 has the same general purposes as House Joint Resolution 748, but would accomplish its purposes by:

(1) Expanding the current training mission of the Department of Medicine and Surgery to assist in providing an adequate supply of health manpower to the Nation;

(2) Providing that any new hospital shall be constructed in close proximity to a medical school which agrees to affiliate;

(3) Expanding Veterans' Administration hospital education and training capacity;

(4) Assisting in the establishment of new medical, health professions, and allied health schools and area health education centers; and

(5) Providing assistance to affiliated medical health professions, and allied health schools and other health manpower training institutions, and area health education centers.

We favor the proposed expansion of the authority of the Administrator of Veterans Affairs to develop and carry out a program of education and training of health manpower beyond the direct needs of the Department of Medicine and Surgery, as contained in section 3 of the bill. This provision is similar to one contained in a draft proposal which the Administrator submitted to the Congress on February 10, 1971, introduced as S. 1924, and currently pending before your committee. However, we do not favor that portion of section 3 which requires that there be included in the budget required to be submitted to Congress a line item showing the estimated expenditure by the Veterans' Administration during each fiscal year for the education and training of health manpower.

The Veterans' Administration pursuant to an agreement with the Office of Management and Budget agreed to revise the activities listed in the program and financing schedule for the medical care appropriation to provide for the separate identification of education and training costs effective with the fiscal year 1972 budget. We feel this action meets the intent of the proposed legislation to make information regarding the agency's estimated expenditures for training and education of health service personnel readily identifiable and available to the Congress. Accordingly, this portion of S. 2219 is unnecessary.

While we recognize and have repeatedly commented on the desirability of locating our hospitals in close proximity to medical schools there are other factors which we feel must also be considered. They include veteran population, concentration, demand, and ability to recruit professional staff. Although one or more of these factors may be enhanced by close location to a medical school, we believe the best policy in this regard is to continue current authority in the Administrator, subject to the approval of the President, as vested by section 5001(c) of title 38, United States Code, to decide where VA hospitals should be located.

Insofar as subchapters I, II, and III of the new chapter 82 proposed in the bill are concerned, they involve grant programs similar to those contained in H.J. Res. 748 and, for the reasons enumerated in my remarks relative to that measure, we do not recommend enactment of S. 2219.

Another bill before your committee, S. 2355, would amend chapter 73 of title 38, United States Code, by adding a new subchapter III providing for the designation by the Administrator of four regional medical education centers. These centers would be used in carrying out the Administrator's functions under section 4101 of title 38 with regard to training of health manpower and would be, to the extent feasible, located in geographically dispersed areas of the United States.

The Veterans' Administration currently has authority, and has for years engaged in a program of continuing education for its staff as an integral part of the operation of the Department of Medicine and Surgery. This activity was reaffirmed in the Government Employees Training Act, now contained in chapter 41 of title 5. For years, we have been authorized, by congressional appropriations to provide Department of Medicine and Surgery employees with postgraduate and inservice training. Moreover, subsection 4101(b) of title 38 clearly recognizes a program of training and education of health service personnel as one of the functions of the Department of Medicine and Surgery of the Veterans' Administration, and since 1968 we have been authorized to share medical information with medical schools, hospitals, research centers, and individual members of the medical profession under the exchange of medical information program authorized by section 5054 of title 38.

We believe that these existing authorities, particularly if they are amended as provided in section 201 of S. 1924, are ample to accomplish all of the purposes set forth in S. 2355.

The next category of bills to which I would like to direct my remarks are those which relate generally to our authority to provide medical care and treatment for veterans.

The first bill in this category is S. 1924 which is identical to a draft bill we submitted to the President of the Senate on May 3, 1971. Briefly it would:

1. Provide a meaningful differential pay program for nurses performing duties on evening or night tours of duty. It would provide for a 10-percent differential pay for each hour a nurse performed duty between 6 p.m. and 6 a.m., and if she performed as much as 4 hours duty between these hours, she would be paid the 10-percent differential pay for her entire 8-hour tour. A nurse performing duty on Sunday would receive additional premium pay at the rate of 25 percent of her basic hourly rate. In addition, overtime pay is authorized for nurses perfoming duties in excess of 8 hours in a day or 40 hours in an administrative workweek at the rate of one and one-half times the employee's basic hourly rate. Additional pay is also provided for work on a holiday. Payment of differential, overtime, and holiday pay on this basis would greatly improve our competitive position in procuring nursing personnel.

2. It amends subsection (f) of section 612 of title 38 to permit furnishing medical services for a nonservice-connected disability not only where such care is reasonably necessary in preparation for hospital admission, but also where such care is reasonably necessary for a veteran who is determined to need hospital care if not treated. This amendment would permit the treatment of a nonservice-connected condition, on an outpatient basis, where such treatment could avoid the necessity for admission to the hospital for treatment. It would extend the present authority in an area which would permit realistic health care being furnished for a nonservice-connected condition at the same time removing the necessity for hospital care which would otherwise be required.

3. It amends section 4101(b) of title 38 to make it clear that the Administrator can furnish training and education to health service personnel beyond the direct needs of the Department of Medicine and Surgery and thus assist in providing an adequate supply of such personnel to meet the needs of the Nation to the extent that this is feasible without interfering with the medical care and treatment of veterans. Current authority, together with the provisions of section 5053 of title 38, has done much to support the education and training programs of the Veterans' Administration and to permit greater participation with the medical community in a more effective utilization of specialized medical resources. Nevertheless, the limitation imposed on our education and training program does, in some measure, impede

our ability to realize our full potential for carrying out programs to increase the availability of qualified health service personnel to meet the needs of the Nation.

4. It would extend the authority of the Veterans' Administration under section 5053 of title 38 to share scarce medical resources by permitting the sharing with medical schools or clinics, regardless of whether such schools or clinics have hospital facilities, and would add a new section 5053(a) which would permit the sharing of hospital beds with supporting services when not needed for the care and treatment of veterans.

In addition S. 1924 includes a clarification of the definition of VA facilities; an extension of malpractice liability protection now provided Department of Medicine and Surgery medical personnel; a provision for two assistant chief medical directors who need not be qualified as doctors of medicine, dental surgery, or dental medicine. Also, an increase in pay for the director of nursing service, chaplain service, pharmacy service, and dietetic service; an additional grade in the nurse schedule; an extension of the maximum period of temporary full-time appointments of health service personnel from 90 days to 1 year; authority to contract for scarce medical specialist services under section 4117 of title 38 with individual physicians. A clarification of VA leasing authority under section 5012 of title 38 to permit the making of such leases without advertising and to allow maintenance, protection, or restoration of the property by the lessee as part or all of the consideration of the lease. A clarification of the Veterans' Administration authority to participate in programs carried out under title IX of the Public Health Service Act, and authority for telephone service to nonphysician hospital directors.

We believe these measures would improve our ability to provide first-class medical care to veterans, and recommend your favorable consideration of this bill.

S. 1635, which is also before your committee is similar in purpose to section 204 of S. 1924, which I have just described. It would provide for the paying of pay differential for evening, night, weekend, and holiday work performed by VA nurses. We would recommend against enactment of S. 1635. As I indicated earlier with respect to the provisions of S. 1924, authority of this nature would greatly improve our competitive position in providing nursing personnel. Accordingly, we favor the approach in section 204 of S. 1924, and urge your committee to give favorable consideration to those provisions.

One of the major bills now before your committee is S. 2354, the Veterans Health Care Reform Act of 1971. This is an omnibus bill containing a number of amendments which would generally extend our authority to provide health, domiciliary and medical care, and provide a number of administrative changes affecting our Department of Medicine and Surgery.

The provisions of this bill are of sufficient number and complexity to make a detailed discussion in this statement impractical. We will, however, submit a report to your committee on the bill which will contain a section-by-section analysis and available cost data on each provision, and set forth the position of the agency on each provision. I can, however, briefly review some of the major provisions of the bill.

Several provisions of this bill would authorize medical care and treatment and related supportive-type assistance to dependents of eligible veterans, on an inpatient, outpatient and domiciliary-care basis. These provisions, which would have the effect of enlarging the class of VA beneficiaries to include nonveterans presents a major question of national policy.

The President has a special concern for the problems of all Americans, including veterans and their dependents, who lack access to adequate medical care. In his health message of last February, he proposed a carefully designed program to assure equal access of Americans to health care; balance supply of health care with demand; and organize medical care delivery on a more efficient basis, emphasizing preventive care and new forms of delivery, including health maintenance organizations.

The classes of beneficiaries which the bill proposes to add as wards of the VA hospital system would be assured access to medical care under the President's proposals. The proposed national health insurance partnership and family health insurance program would, in combination with social security benefits, provide comprehensive health protection for both working and retired Americans. For veterans, survivors, dependents, and peace time veterans, this coverage would be superior to the care provided in this bill in two major respects. It gives beneficiaries a choice of care in their communities, and it provides preventive and maintenance health care.

The approach of this bill, in adding potentially 40 million adults and children to the patient care liability of the VA hospital system, threatens to so overload the capacity of VA's system as to render it unable to provide quality care for those beneficiaries for whom the system was originally established and who remain the prime obligation of the Government—the service-disabled veterans.

On the other hand, the President shares the Congress' concern that the unique capabilities of the VA medical system be used to help improve delivery of medical care to the American people. He has specifically directed the Administrator of Veterans Affairs to develop ways in which the VA medical system can be used to supplement local medical resources in scarcity areas.

With regard to peacetime veterans, historically, hospitalization of veterans for nonservice-connected conditions has been limited to veterans of wartime service, and we cannot recommend a change in this philosophy.

For these reasons, we must oppose those provisions of the bill which would extend VA medical care to nonveterans and peacetime veterans.

There are a number of other provisions in the bill which would establish certain mandatory requirements with respect to the administration of our system which we believe would limit our ability to provide qualified medical care. We are furnishing the chairman with the reports. I think this should be quality medical care. For example, section 201 would require staff-patient ratios similar to that of other area hospitals, regardless of whether those ratios were excess to the needs of the veterans being treated or whether the facilities of the hospitals used as guide hospitals had facilities similar to those of the VA hospitals. Section 301(a) of the bill includes requirements for the average daily bed census, would require 6,000 nursing home beds, and requires the conversion of unused hospital beds into nursing home beds. We believe these mandatory requirements are unwise and should not supersede the flexibility we now have to make decisions of this nature based on present need, staffing, and future planning.

Several sections of the bill would have the effect of removing approximately 52,000 VA general schedule allied professional and health technician employees from competitive service appointments, classification, and pay, and place such employees in the excepted service under new pay schedules in title 38. We are strongly opposed to the exception of such positions from the Civil Service Commission laws and rules, and from the general schedule which governs classification and pay. We can see no justification for such exception. Moreover, under the terms of Public Law 91–216, Job Evaluation Policy Act of 1970, the Civil Service Commission is presently required to provide the Congress a plan for establishment of a coordinated system of job evaluation and ranking of Federal civilian positions.

There are several other provisions of the bill which would affect administrative and pay of personnel of the Department of Medicine and Surgery, which we strongly oppose. For example, section 206 would authorize up to a 20-percent pay increase for any physician who performs administrative duties and special geographic pay differentials.

In lieu of the nurse differential pay increases proposed in section 206(c) of the bill, we recommend that the formula set forth in S. 1924 be adopted.

We do not favor the provisions established in section 206 which would authorize retirement credit for civil service retirement purposes for physicians and dentists for the period of time devoted to the pursuit of their professional degree and for the time devoted to a full-time internship program. To allow retirement benefits which are not based on a period of "service" within the basic concept of such term under the civil service retirement system would, we believe, be contrary to established precedent and would also be discriminatory against other professionals who underwent similar periods of education in order to accomplish their professional goal.

There are, however, a number of provisions of this bill which we favor, either in whole or in part. For example, we favor a provision such as suggested in section 103(a)(4) which would authorize the prehospital outpatient care of veterans where such treatment would obviate the need for future hospitalization. We suggest, however, that the language contained in S. 1924 be adopted to accomplish this objective.

We favor the provisions of section 210 which would extend and clarify the malpractice liability protection for medical personnel of the Department of Medicine and Surgery.

We favor the administrative provisions set forth in sections 202 and 206(a) relating to the appointment of two additional assistant chief medical directors, and the establishment of new rates of pay for the director of nursing service, dietetic service, chaplain service, and pharmacy service.

We favor the central administration of intern and residency programs as provided in section 209. We also favor the clarification of our authority to contract for scarce medical specialists which would be provided by section 211 of the bill, and our authority to enter into sharing agreements with clinics and medical schools which would be provided by section 303 of the bill. We also favor the authority to simplify the leasing of excess property which would be provided by section 302 of the bill, and the authority to provide free telephone service for nonphysician directors which would be provided by section 305 of the bill.

In summary, there are many of the provisions of S. 2354 which we favor. There are others, however, to which we strongly object. For this reason, we recommend against enactment of this bill. Moreover, we reiterate that S. 1924 would accomplish the majority of provisions we favor.

Also before your committee is S. 739, which would require that VA hospitals and domiciliaries be earthquake resistant. This provision is similar to the provisions of section 301(b) of S. 2354. Both of these provisions would make a statutory requirement for action we are now already taking. Accordingly, we do not believe such statutory action is necessary.

Also before your committee is S. 2340, 92d Congress, a bill to amend title 38, United States Code, to provide for a rebuttable presumption that any disability of a veteran of any war, or of service after January 31, 1955, who is a former prisoner of war, or while in the line of duty was forceably detained or interned by a foreign government or power, is service connected for the purpose of entitlement to VA hospitalization and outpatient care at VA expense in a foreign country, provided pertinent medical records are unavailable.

Under the existing provisions of section 610 of title 38, United States Code, the Administrator, within the limits of Veterans' Administration facilities, may furnish hospital care which he determines is needed to any veteran for a service-connected disability. Hospitalization for a non-service-connected disability, however, may be furnished only if the veteran has wartime service, or service after January 31, 1955, and is unable to defray the expenses of necessary hospital care.

With certain exceptions, not here pertinent, section 612 presently provides that veterans are not eligible for outpatient treatment from the Veterans' Administration for a non-service-connected disorder unless it is associated with and held to be aggravating a service-connected condition.

Statutory presumptions usually presuppose the existence of certain diseases for a period of time before symptoms or clinically demonstrated manifestations appear. A rebuttable presumption of service connection for all disabilities, regardless of the nature of their onset or whether from causes occurring after service, as proposed by this legislation, is not medically justifiable. This is also applicable to chronic diseases having an insidious onset as well as to acute conditions of infectious or traumatic origin and chronic disabilities of intercurrent infectious or traumatic origin. The expiration of a period of time, which is usually computed in terms of years, between an experience and the manifestations of symptoms of unknown pathogenesis would ordinarily rebut any concept of etiological relationship. Making the presumption rebuttable would, therefore, categorically negate the effect of the proposed law where there has been a substantial lapse of time.

The proposed legislation, therefore, presents a policy question as to how far the Government should go in treating a veteran's condition which bears no relation to his service and often occurs years after his discharge from service.

In considering this question, it should be kept in mind that former prisoners of war are now given special consideration under the laws administered by the Veterans' Administration. Our regulations and directives also contain liberal provisions with respect to the claim of any such person for disabilities for the purpose of entitlement to VA benefits including medical benefits. Section 354(a) of title 38, United States Code, requires that in the adjudication of service connection for any disability due consideration will be given to the places, types, and circumstances of service. Section 354(b) provides liberalized criteria for determining service connection of any disease or injury for those veterans who engaged in combat with enemy. Section 612(b)(3) authorizes unlimited outpatient dental services and treatment, and related dental appliances, for any service-connected condition of a veteran who was a prisoner of war.

Veterans' Administration regulations emphasizing the liberality which is accorded in prisoner-of-war cases include, for example, a provision that the development of symptomatic manifestations of a preexisting injury or disease during or closely following a status as a prisoner of war will establish aggravation. Physical examinations of former prisoners of war are conducted with particular thoroughness to discover, if possible, all disabilities common to prisoners of war even where there has been no complaint or prior evidence of such condition. Existing instructions provide that in the evaluation of disabilities resulting from or incident to military service, great weight must be assigned to imprisonment or internment under unsanitary conditions or to food deprivation in the service connection of dysentery and other gastrointestinal diseases. All of these considerations permit the Veterans' Administration to reach an equitable decision on the basis of the facts of each individual case, with any reasonable doubt being resolved in favor of the former prisoner of war.

We believe that special consideration should be given to former prisoners of war and strive to assure that they receive all benefits in full measure under the law. However, we do not think that former prisoner-of-war status justifies a lifetime of total medical care for conditions having no relation to service. There seems little justification for giving preference solely on this basis when many who underwent comparable privations and hardships, as for example in extended combat, would not be afforded similar consideration.

We are also gravely concerned lest the grant of a rebuttable presumption of service connection for medical benefits would provide a precedent for demands by former prisoners of war or other groups for expansion of the presumption to cover claims for compensation or other benefits. Furthermore, an extension of medical benefits to former prisoners of war for virtually all disabilities on the basis of a rebuttable presumption would tend to destroy the meaning of the term "service connection." Since its inception, this term has had a special meaning which has rarely been diluted.

For the reasons indicated above, and since we believe that liberal treatment is already being accorded former prisoners of war under existing laws and procedures, the Veterans' Administration recommends that S. 2340, not be favorably considered by your committee.

Still another bill now before you is S. 879, 92d Congress, a bill to "amend chapter 17 of title 38, United States Code, to authorize the Veterans' Administration to provide hospital and domiciliary care to peacetime veterans who are unable to defray the expenses thereof."

Historically, hospitalization of veterans for non-service-connected conditions has been limited to veterans of wartime service. Although Public Law 89–358 amended section 610(a)(1)(B) to include as eligible veterans those having served after January 31, 1955, providing no terminal date, it is not believed that there was any intent to depart from the aforesaid historical limitation. To the contrary, the failure to include a terminal date was, in our view, an effort by the Congress to extend wartime benefits during the so-called cold war period without attempting to define each incident giving rise to wartime conditions which might occur. It left the way open for a future Congress, when conditions have changed, to place a termination date for that period of service for which these benefits would be afforded. Enactment of S. 879 extending eligibility for hospitalization of veterans for non-service-connected conditions to peacetime veterans would preclude the Congress from exercising its present option to fix such a terminal date.

For the foregoing reason, we cannot recommend that your committee give favorable consideration to the enactment of S. 879, 92d Congress.

Finally, I would like to discuss H.R. 431 which would authorize the Administrator of Veterans Affairs with respect to Federal lands under his jurisdiction to relinquish to a State in which the land is situated such measure of legislative jurisdiction as he deems desirable. The relinquishment of jurisdiction would be subject to acceptance by the State.

The language now contained in the bill is identical to that already extended to the military departments in the Military Construction Authorization Act of 1971, Public Law 91–511, and was designed to give the Administrator sufficient elasticity to meet any situation which might arise. Members of the committee staff have raised a question as to why the proposed authority was not limited to the relinquishment to the State of only concurrent jurisdiction such as provided in Public Law 91–45 dealing with Fort Harrison, Mont. The language of Public Law 91–45 was designed to meet the specific situation existing at that station as distinguished from the present bill which is designed to meet all contingencies which might arise. In all honesty, I cannot, at the present time, visualize a situation where we might wish to afford to the State more than concurrent jurisdiction. Although we would prefer the present language of the bill which would provide for all further contingencies, if it were amended to limit the Administrator's authority to relinquish only so much of our legislative jurisdiction as to grant concurrent jurisdiction to the State. we believe the fundamental purpose toward which it was directed would be accomplished.

In view of the present problems which exist in some Veterans' Administration stations, we would urge early and favorable consideration of H.R. 481.

Mr. Chairman, that concludes my statement. I would be happy to answer any question you might have.

(The prepared statement of Dr. Marc Musser follows:)

STATEMENT OF MARC J. MUSSER, CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION

Mr. Chairman and members of the committee: I would like to thank you for affording me this opportunity to appear before you and present the views of the Veterans Administration relative to the several bills now before you for consideration. I would like to first introduce to you the members of the VA staff who are accompanying me and will be available to answer any questions that the members of the Committee may have.

Initially, I would like to state that we are furnishing the Chairman of the full Committee with reports on all the measures under consideration. These reports contain our detailed analysis and views on each measure and the cost thereof. I will, therefore, limit my testimony to a general discussion of several of the more important aspects of the legislation now before you.

The first of these bills which I will discuss is H.J. Res. 748 which would expand the health manpower pool of the Nation through the establishment of new medical schools and the improvement of existing medical and health professions schools affiliated with Veterans Administration hospitals, in order to assure an adequate supply of physicians, health professionals, allied health personnel, and other health personnel to provide the best possible medical care for veterans.

It would add a new chapter 82 to title 38, United States Code, containing three new subchapters.

Subchapter I would authorize the Administration to implement a pilot program under which he may provide assistance in the establishment of not more than five new State medical schools if such schools are located in proximity to, and operated in conjunction with, Veterans Administration medical faciilties.

Subchapter II would authorize the Administrator to carry out a program of grants, on a matching basis, for medical schools which have maintained affiliation with the Veterans Administration in order to assist such schools to improve and enlarge their facilities. For this purpose, $15 million would be authorized to be appropriated for the fiscal year ending June 30, 1972, and a like sum for each of the six succeeding fiscal years.

For over 25 years, hospitals of the Veterans Administration have been offering hospital-based educational experience in collaboration with most of the Nation's medical schools. Veterans Administration hospitals are currently affiliated with 81 medical schools, 51 dental schools, 287-nursing schools, 274 universities and colleges and 84 community and junior colleges. During the current fiscal year, more than 50,000 students will participate in more than 60 categories of training in Veterans Administration institutions. Thus, the Veterans Administration's contribution in the field of health education has been substantial.

The success and productivity of this partnership between an agency of the Government and the non-Federal system of higher education in the interest of the entire health care system has won the confidence and support of all. However, we do not feel that the placing of grant authority in the Veterans Administration for the purposes set forth in H.J. Res. 748 is the proper approach for expanding medical education facilities to meet the broad national needs. Instead, it would duplicate and overlap current authorities under the Health Professions Educational Assistance provisions of titles VII and VIII of the Public Health Service Act to assist in the establishment of new schools of medicine, the expansion of existing schools, the provision of operating support under both formula and special project grants, and the training of health service personnel.

We feel that the enactment of this legislation would contribute to a fragmentation of authority at a time when the President has emphasized the need for consolidation and coordination of granting mechanisms throughout the Federal Government. Legislation to accomplish this objective, as spelled out in the President's "Health Message" to the Congress on February 18, 1971, is presently pending before the Congress. Accordingly, the VA is strongly opposed to the enactment of H.J. Res. 748.

S.J. Res. 128, except for the title, is identical to H.J. Res. 748, and my foregoing remarks are equally applicable thereto.

S.J. Res. 76, while not identical to H.J. Res. 748, has the same purpose, and S. 2304, although limited in scope to education opportunities for veterans, would, in general, accomplish a similar objective through grant programs. However, section 2 of S.J. Res. 76 provides that for a two-year period immediately following the date of enactment, no part of any real property, under the jurisdiction of the Administrator of Veterans Affairs, on January 1, 1971, shall be determined to be excess to the needs of the Veterans Administration, or transferred, or otherwise disposed of, pursuant to any provision of the Federal Property and Administrative Services Act of 1949.

Present Veterans Administration policy is to review of our real property holdings to determine whether such holdings are excess to our needs, and in our master planning for optimum land use in accordance with long-range plans, include in the criteria for consideration, possible use for affiliated medical schools or health care training facilities, as well as Veterans Administration physical facilities, roads and parking, recreation areas, overall esthetics, buffer zones, easement granted to public utility companies, state, or local governments, topography, and cemeteries, to assure that land which is essential to Veterans Administration activities and responsibilities is not mistakenly declared excess. We feel that this policy assures the maintenance of all Veterans Administration interests in real property necessary to our long-range planning, and that the provisions of section 2 of the resolution impose an undue and unneccessary limitation on the authority of the Executive branch of the Government to dispose of real property excess to the present and future needs of the Federal Government.

My views with respect to H.J. Res. 748 are equally applicable to S.J. Res. 76 and S. 2304, and I would recommend against their favorable consideration.

S. 2219 has the same general purposes as S.J. Res. 748, but would accomplish its purposes by:

1. Expanding the current training mission of the Department of Medicine and Surgery to assist in providing an adequate supply of health manpower to the Nation;
2. Providing that any new hospital shall be constructed in close proximity to a medical school which agrees to affiliate;
3. Expanding Veterans Administration hospital education and training capacity;
4. Assisting in the establishment of new medical, health professions, and allied health schools and area health education centers; and
5. Providing assistance to affiliated medical, health professions, and allied health schools and other health manpower training institutions, and area health education centers.

We favor the proposed expansion of the authority of the Administrator of Veterans Affairs to develop and carry out a program of education and training of health manpower beyond the direct needs of the Department of Medicine and Surgery, as contained in section 3 of the bill. This provision is similar to one contained in a draft proposal which the Administrator submitted to the Congress on February 10, 1971, introduced as S. 1924, and currently pending before your Committee. However, we do not favor that portion of section 3 which requires that there be included in the budget required to be submitted to Congress a line item showing the estimated expenditure by the Veterans Administration during each fiscal year for the education and training of health manpower.

The Veterans Administration pursuant to an agreement with the Office of Management and Budget agreed to revise the activities listed in the Program and Financing Schedule for the Medical Care appropriation to provide for the separate identification of education and training costs effective with the fiscal year 1972 budget. We feel this action meets the intent of the proposed legislation to make information regarding the agency's estimated expenditures for training and education of health service personnel readily identifiable and available to the Congress. Accordingly, this portion of S. 2219 is unnecessary.

While we recognize and have repeatedly commented on the desirability of locating our hospitals in close proximity to medical schools, there are other factors which we feel must also be considered. They include veteran-population, concentration, demand, and ability to recruit professional staff. Although one or more of these factors may be enhanced by close location to a medical school, we believe the best policy in this regard is to continue current authority in the Administrator, subject to the approval of the President, as vested by section 5001(c) of title 38, United States Code, to decide where VA hospitals should be located.

Insofar as subchapters I, II and III of the new chapter 82 proposed in the bill are concerned, they involve grant programs similar to those contained in H.J. Res. 748 and, for the reasons enumerated in my remarks relative to that measure, we do not recommend enactment of S. 2219.

Another bill before your Committee, S. 2355, would amend chapter 73 of title 38, United States Code, by adding a new subchapter III providing for the designation by the Administrator of four regional medical education centers. These centers would be used in carrying out the Administrator's functions under section 4101 of title 38 with regard to training of health manpower and would be, to the extent feasible, located in geographically dispersed areas of the United States.

The Veterans Administration currently has authority, and has for years engaged in a program of continuing education for its staff as an integral part of the operation of the Department of Medicine and Surgery. This activity was reaffirmed in the Government Employees Training Act (now contained in chapter 41 of title 5). For years, we have been authorized, by Congressional appropriations to provide Department of Medicine and Surgery employees with postgraduate and in-service training. Moreover, subsection 4101(b) of title 38 clearly recognizes a program of training and education of health service personnel as one of the functions of the Department of Medicine and Surgery of the Veterans Administration, and since 1968 we have been authorized to share medical information with medical schools, hospitals, research centers, and individual members of the medical profession under the exchange of medical information program authorized by section 5054 of title 38. We believe that these existing authorities, particularly if they are amended as provided in section 201 of S. 1924, are ample to accomplish all of the purposes set forth in S. 2355.

The next category of bills to which I would like to direct my remarks are those which relate generally to our authority to provide medical care and treatment for veterans.

The first bill in this category is S. 1924 which is identical to a draft bill we submitted to the President of the Senate on May 3, 1971. Briefly, it would:

1. Provide a meaningful differential pay program for nurses performing duties on evening or night tours of duty. It would provide for a 10 percent differential pay for each hour a nurse performed duty between 6 p.m. and 6 a.m., and if she performed as much as four hours' duty between these hours, she would be paid the 10 percent differential pay for her entire 8-hour tour; a nurse performing duty on Sunday would receive additional premium pay at the rate of 25 percent of her basic hourly rate. In addition, overtime pay is authorized for nurses performing duties in excess of 8 hours in a day or 40 hours in an administrative workweek at the rate of one and one-half times the employee's basic hourly rate. Additional pay is also provided for work on a holiday. Payment of differential, overtime, and holiday pay on this basis would greatly improve our competitive position in procuring nursing personnel.

2. It amends subsection (f) of section 612 of title 38 to permit furnishing medical services for a non-service-connected disability not only where such care is reasonably necessary in preparation for hospital admission but also where such care is reasonably necessary for a veteran who is determined to need hospital care if not treated. This amendment would permit the treatment of a non-service-connected condition, on an outpatient basis, where such treatment could avoid the necessity for admission to the hospital for treatment. It would extend the present authority in an area which would permit realistic health care being furnished for a non-service-connected condition at the same time removing the necessity for hospital care which would otherwise be required.

3. It amends section 4101(b) of title 38 to make it clear that the Administrator can furnish training and education to health service personnel beyond the direct needs of the Department of Medicine and Surgery and thus assist in providing an adequate supply of such personnel to meet the needs of the Nation to the extent that this is feasible without interfering with the medical care and treatment of veterans. Current authority, together with the provisions of section 5053 of title 38, has done much to support the education and training programs of the Veterans Administration and to permit greater participation with the medical community in a more effective utilization of specialized medical resources. Nevertheless, the limitation imposed on our education and training program does, in some measure, impede our ability to realize our full potential for carrying out programs to increase the availability of qualified health service personnel to meet the needs of the Nation.

4. It would extend the authority of the Veterans Administration under section 5053 of title 38 to share scarce medical resources by permitting the sharing with medical schools or clinics, regardless of whether such schools or clinics have hospital facilities, and would add a new section 5053(a) which would permit the sharing of hospital beds with supporting services when not needed for the care and treatment of veterans.

In addition, S. 1924 includes:

A clarification of the definition of VA facilities;

An extension of malpractice liability protection now provided Department of Medicine and Surgery medical personnel;

A provision for two Assistant Chief Medical Directors who need not be qualified as doctors of medicine, dental surgery, or dental medicine;

An increase in pay for the Director of Nursing Service, Chaplain Service, Pharmacy Service, and Dietetic Service;

An additional grade in the Nurse Schedule;

An extension of the maximum period of temporary full-time appointments of health service personnel from 90 days to one year;

Authority to contract for scarce medical specialist services under section 4117 of title 38 with individual physicians;

A clarification of VA leasing authority under section 5012 of title 38 to permit the making of such leases without advertising and to allow maintenance, protection, or restoration of the property by the lessee as a part or all of the consideration of the lease;

A clarification of the Veterans Administration authority to participate in programs carried out under title IX of the Public Health Service Act; and

Authority for telephone service to non-physician hospital directors.

We believe these measures would improve our ability to provide first class medical care to veterans, and recommend your favorable consideration of this bill.

S. 1635, which is also before your Committee is similar in purpose to section 204 of S. 1924, which I have just described. It would provide for the paying of pay differential for evening, night, weekend, and holiday work performed by VA nurses. We would recommend against enactment of S. 1635. As I indicated earlier with respect to the provisions of S. 1924, authority of this nature would greatly improve our competitive position in providing nursing personnel. Accordingly, we favor the approach in section 204 of S. 1924, and urge your Committee to give favorable consideration to those provisions.

One of the major bills now before your Committee is S. 2354, the "Veterans Health Care Reform Act of 1971." This is an omnibus bill containing a number of amendments which would generally extend our authority to provide health, domiciliary and medical care, and provide a number of administrative changes affecting our Department of Medicine and Surgery.

The provisions of this bill are of sufficient number and complexity to make a detailed discussion in this statement impractical. We will, however, submit a report to your Committee on the bill which will contain a section-by-section analysis and available cost data on each provision, and set forth the position of the agency on each provision. I can, however, briefly review some of the major provisions of the bill.

Several provisions of this bill would authorize medical care and treatment and relating supportive type assistance to dependents of eligible veterans, on an inpatient, outpatient and domiciliary care basis. These provisions, which would have the effect of enlarging the class of VA beneficiaries to include non-veterans presents a major question of national policy.

The President has a special concern for the problems of all Americans, including veterans and their dependents, who lack access to adequate medical care. In his Health Message of last February, he proposed a carefully designed program to:

> Assure equal access of Americans to health care;
>
> Balance supply of health care with demand; and
>
> Organize medical care delivery on a more efficient basis; emphasizing preventive care and new forms of delivery, including health maintenance organizations.

The classes of beneficiaries which the bill proposes to add as wards of the VA hospital system would be assured access to medical care under the President's proposals. The proposed National Health Insurance Partnership and Family Health Insurance Program would, in combination with Social Security benefits, provide comprehensive health protection for both working and retired Americans. For veterans' survivors, dependents, and peacetime veterans, this coverage would be superior to the care provided in this bill in two major respects:

It gives beneficiaries a choice of care in their communities; and

It provides preventive and maintenance health care.

The approach of this bill, in adding potentially 40 million adults and children to the patient care liability of the VA hospital system, threatens to so overload the capacity of VA's system as to render it unable to provide quality care for those beneficiaries for whom the system was originally established and who remain the prime obligation of the Government—the service-disabled veterans.

On the other hand, the President shares the Congress' concern that the unique capabilities of the VA medical system be used to help improve delivery of medical care to the American people. He has specifically directed the Administrator of Veterans Affairs to develop ways in which the VA medical system can be used to supplement local medical resources in scarcity areas.

With regard to peacetime veterans, historically, hospitalization of veterans for non-service connected conditions has been limited to veterans of wartime service, and we cannot recommend a change in this philosophy.

For these reasons, we must oppose those provisions of the bill which would extend VA medical care to non-veterans and peacetime veterans.

There are a number of other provisions in the bill which would establish certain mandatory requirements with respect to the administration of our system which we believe would limit our ability to provide qualified medical care. For example, section 201 would require staff-patient ratios similar to that of other area hospitals, regardless of whether those ratios were excess to the needs of the veterans being treated or whether the facilities of the hospitals used as guide hospitals had facilities similar to those of the VA hospitals. Section 301(a) of the bill includes requirements for the average daily bed census, would require 6,000 nursing home beds, and requires the conversion of unused hospital beds into nursing home beds. We believe these mandatory requirements are unwise and should not supercede the flexibility we now have to make decisions of this nature based on present need, staffing and future planning.

Several sections of the bill would have the effect of removing approximately 52,000 VA General Schedule allied professional and health technician employees from competitive service appointments, classification, and pay, and place such employees in the excepted service under new pay schedules in title 38. We are strongly opposed to the exception of such positions from the Civil Service Commission laws and rules, and from the General Schedule which governs classification and pay. We can see no justification for such exception. Moreover, under the terms of Public Law 91-216, Job Evaluation Policy Act of 1970, the Civil Service Commission is presently required to provide the Congress a plan for establishment of a coordinated system of job evaluation and ranking of Federal civilian positions.

There are several other provisions of the bill which would affect administrative and pay of personnel of the Department of Medicine and Surgery, which we strongly oppose. For example, section 206 would authorize up to a 20 percent pay increase for any physician who performs administrative duties and special geographic pay differentials.

In lieu of the nurse differential pay increases proposed in section 206(c) of the bill, we recommend that the formula set forth in S. 1924 be adopted.

We do not favor the provisions established in section 206 which would authorize retirement credit for civil service retirement purposes for physicians and dentists for the period of time devoted to the pursuit of their professional degree and for the time devoted to a full-time internship program. To allow retirement benefits which are not based on a period of "service" within the basic concept of such term under the civil service retirement system would, we believe, be contrary to established precedent and would also be discriminatory against other professionals who underwent similar periods of education in order to accomplish their professional goal.

There are, however, a number of provisions of this bill which we favor, either in whole or in part. For example, we favor a provision such as suggested in section 103(a)(4) which would authorize the prehospital outpatient care of veterans where such treatment would obviate the need for future hospitalization. We suggest, however, that the language contained in S. 1924 be adopted to accomplish this objective.

We favor the provisions of section 210 which would extend and clarify the malpractice liability protection for medical personnel of the Department of Medicine and Surgery.

We favor the administrative provisions set forth in section 202 and 206(a) relating to the appointment of two additional Assistant Chief Medical Directors, and the establishment of new rates of pay for the Director of Nursing Service, Dietetic Service, Chaplain Service, and Pharmacy Service.

We favor the central administration of intern and residency programs as provided in section 209. We also favor the clarification of our authority to contract for scarce medical specialists which would be provided by section 211 of the bill, and our authority to enter into sharing agreements with clinics and medical schools which would be provided by section 303 of the bill. We also favor the authority to simplify the leasing of excess property which would be provided by section 302 of the bill, and the authority to provide free telephone service for non-physician directors which would be provided by section 305 of the bill.

In summary, there are many of the provisions of S. 2354 which we favor. There are others, however, to which we strongly object. For this reason, we recommend against enactment of this bill. Moreover, we reiterate that S. 1924 would accomplish the majority of provisions we favor.

Also before your Committee is S. 739, which would require that VA hospitals and domiciliaries be earthquake resistant. This provision is similar to the provisions of section 301(b) of S. 2354. Both of these provisions would make a statutory requirement for action we are now already taking. Accordingly, we do not believe such statutory action is necessary.

Also before your Committee is S. 2340, 92nd Congress, a bill to amend title 38, United States Code, to provide for a rebuttable presumption that any disability of a veteran of any war, or of service after January 31, 1955, who is a former prisoner of war or while in the line of duty was forceably detained or interned by a foreign government or power, is service-connected for the purpose of entitlement to VA hospitalization and out-patient care at VA expense in a foreign country provided pertinent medical records are unavailable.

Under the existing provisions of section 610 of title 38, United States Code, the Administrator, within the limits of Veterans Administration facilities, may furnish hospital care which he determines is needed to any veteran for a service-connected disability. Hospitalization for a non-service-connected disability, however, may be furnished only if the veteran has wartime service, or service after January 31, 1955, and is unable to defray the expenses of necessary hospital care.

With certain exceptions, not here pertinent, section 612 presently provides that veterans are not eligible for out-patient treatment from the Veterans Administration for a non-service-connected disorder unless it is associated with and held to be aggravating a service-connected condition.

Statutory presumptions usually presuppose the existence of certain diseases for a period of time before symptoms or clinically demonstrated manifestations appear. A rebuttable presumption of service connection for all disabilities, regardless of the nature of their onset or whether from causes occurring after service, as proposed by this legislation, is not medically justifiable. This is also applicable to chronic diseases having an insidious onset as well as to acute conditions of infectious or traumatic origin and chronic disabilities of intercurrent infectious or traumatic origin. The expiration of a period of time, which is usually computed in terms of years, between an experience and the manifestations of symptoms of unknown pathogenesis would ordinarily rebut any concept of etiogolical relationship. Making the presumption rebuttable would, therefore, categorically negate the effect of the proposed law where there has been a substantial lapse of time.

The proposed legislation, therefore, presents a policy question as to how far the Government should go in treating a veteran's condition which bears no relation to his service and often occurs after his discharge from service.

In considering this question, it should be kept in mind that former prisoners of war are now given special consideration under the laws administered by the Veterans Administration. Our regulations and directives also contain liberal provisions with respect to the claim of any such person for disabilities for the purpose of entitlement to VA benefits including medical benefits. Section 354(a) of title 38, United States Code, requires that in the adjudication of service connection for any disability due consideration will be given to the places, types, and circumstances of service. Section 354(b) provides liberalized criteria for determining service connection of any disease or injury for those veterans who engaged in combat with enemy. Section 612(b)(3) authorizes unlimited outpatient dental services and treatment, and related dental appliances, for any service-connected condition of a veteran who was a prisoner of war.

Veterans Administration regulations emphasizing the liberality which is accorded in prisoner of war cases include, for example, a provision that the development of symptomatic manifestations of a preexisting injury or disease during or closely following a status as a prisoner of war will establish aggravation.

Physical examinations of former prisoners of war are conducted with particular thoroughness to discover, if possible, all disabilities common to prisoners of war even where there has been no complaint or prior evidence of such condition. Existing instructions provide that in the evaluation of disabilities resulting from or incident to military service, great weight must be assigned to imprisonment or internment under unsanitary conditions or to food deprivation in the service connection of dysentery and other gastrointestinal diseases. All of these considerations permit the Veterans Administration to reach an equitable decision on the basis of the facts of each individual case, with any reasonable doubt being resolved in favor of the former prisoner of war.

We believe that special consideration should be given to former prisoners of war and strive to assure that they receive all benefits in full measure under the law. However, we do not think that former prisoner of war status justifies a lifetime of total medical care for conditions having no relation to service. There seems little justification for giving preference solely on this basis when many who uderwent comparable privations and hardships, as for example in extended combat, would not be afforded similar consideration.

We are also gravely concerned lest the grant of a rebuttable presumption of service connection for medical benefits would provide a precedent for demands by former prisoners of war or other groups for expansion of the presumption to cover claims for compensation or other benefits. Furthermore, an extension of medical benefits to former prisoners of war for virtually all disabilities on the basis of a rebuttable presumption would tend to destroy the meaning of the term "service connection". Since its inception, this term has had a special meaning which has rarely been diluted.

For the reasons indicated above, and since we believe that liberal treatment is already being accorded former prisoners of war under existing laws and procedures, the Veterans Administration recommends that S. 2340 not be favorably considered by your Committee.

Still another bill now before you is S. 879, 92nd Congress, a bill "To amend chapter 17 of title 38, United States Code, to authorize the Veterans' Administration to provide hospital and domiciliary care to peacetime veterans who are unable to defray the expenses thereof".

Historically, hospitalization of veterans for non-service-connected conditions has been limited to veterans of wartime service. Although P.L. 89-358 amended Section 610(a)(1)(B) to include as eligible veterans those having served after January 31, 1955, providing no terminal date, it is not believed that there was any intent to depart from the aforesaid historical limitation. To the contrary, the failure to include a terminal date was, in our view, an effort by the Congress to extend wartime benefits during the so-called "cold war period" without attempting to define each incident giving rise to wartime conditions which might occur. It left the way open for a future Congress, when conditons have changed, to place a termination date for that period of service for which these benefits would be afforded. Enactment of S. 879 extending eligibility for hospitalization of veterans for non-service-connected conditions to peacetime veterans would preclude the Congress from exercising its present option to fix such a terminal date.

For the foregoing reason, we cannot recommend that your Committee give favorable consideration to the enactment of S. 879, 92nd Congress.

Finally, I would like to discuss H.R. 481 which would authorize the Administrator of Veterans Affairs with respect to Federal lands under his jurisdiction to relinquish to a state in which the land is situated such measure of legislative jurisdiction as he deems desirable. The relinquishment of jurisdiction would be subject to acceptance by the state.

The language now contained in the bill is identical to that already extended to the military departments in the Military Construction Authorization Act of 1971, Public Law 91-511, and was designed to give the Administrator sufficient elasticity to meet any situation which might arise. Members of the Committee staff have raised a question as to why the proposed authority was not limited to the relinquishment to the state of only concurrent jurisdiction such as provided in Public Law 91-45 dealing with Fort Harrison, Montana. The language of Public Law 91-45 was designed to meet the specific situation existing at that station as distinguished from the present bill which is designed to meet all contingencies which might arise. In all honesty, I cannot, at the present time, visualize a situation where we might wish to afford to the state more than concurrent jurisdiction. Although we would prefer the present language of the bill which would provide for all further contingencies, if it were amended to limit the Administrator's authority to relinquish only so much of our legislative jurisdiction as to grant concurrent jurisdiction to the state, we believe the fundamental purpose toward which it was directed would be accomplished.

In view of the present problems which exist in some Veterans Administration stations, we would urge early and favorable consideration of H.R. 481.

Senator CRANSTON. Thank you very much for that thorough and detailed statement. I am sorry that we were not able to have it earlier so that we could have studied it more carefully before you presented it, but I understand that was not your fault.

Dr. MUSSER. That is right.

Senator CRANSTON. I do have a great many questions to ask you, and more to submit for the record after studying your statement.

Speaking professionally, what do you see as the importance of the Veterans' Administration's relationship with health manpower training institutions? Would you say that the VA cannot compete for good quality staff, particularly physicians, in most areas without active medical school academic affiliations?

Dr. MUSSER. Certainly the affiliation with medical schools has been immensely important, if not crucial, in our ability to recruit top quality staff.

Senator CRANSTON. Would it be more difficult if you did not have affiliations?

Dr. MUSSER. Yes, it would.

Senator CRANSTON. Do you have anything to add to that Dr. Wells?

Dr. WELLS. Only by way of emphasis, I think the affiliations have really been the lifeblood of VA as far as quality medical care is concerned, and that affiliation is as relevant now as it was in 1946.

Senator CRANSTON. Dr. Musser, do you also agree that the quality of health care the VA is able to provide to disabled veterans depends to a considerable extent on the viability of these teaching affiliations and the opportunity for research?

Dr. MUSSER. Yes, I think this has been demonstrated many times.

Senator CRANSTON. Can you describe the history and progress of the new medical school at the Shreveport, La., VA Hospital?

Dr. MUSSER. Actually Dr. Wells was very instrumental in developing that school. I would like to ask him to answer your question.

Dr. WELLS. Thank you, Mr. Chairman. Some years ago I visited Shreveport, at the time the State was thinking of a new medical school. We found that our hospital there had some excess space because of the fact that it had originally contained a regional office and clinic and these were not functional at the time. This gave us a unique opportunity to invite the school to work with us, and us with them, in the development of spaces in that hospital, which included offices, laboratories for teaching, and so on.

This very quickly became an active affiliation between us and the medical school at Shreveport. Our staff was changed in such a way as to have most of our members on the faculty of the new medical school and to increase the amount of research that was being done at that institution as well.

We think that we accomplished a rather outstanding goal here inasmuch as the new medical school was able to swing into action and to accept medical students in a much shorter time than is usually possible in new medical schools.

In an analysis of some 16 medical schools established after World War II, it was the experience that it took about 3½ to 5 years before medical students could be admitted. In this particular situation medical students were admitted approximately 14 months after the initial resolution to have the school. So this of itself was a rather outstanding result. There was also the fact that by having the VA facility, we materially reduced the cost of initiating this medical school for the University of Louisiana. This process has gone on. There have been two classes now of approximately 33 each. It is a very successful operation; successful from both the standpoint of the medical school for the University of Louisiana, and successful from our standpoint by upgrading the quality of care in our Shreveport hospital.

Senator Cranston. Thank you very much.

Whichever one of you would like to, would you describe the situation with respect to Rutgers Medical School and the East Orange VA Hospital?

Dr. Musser. These are two different situations. Both of us could answer the questions. I will take Rutgers and let Dr. Wells talk about East Orange, because again he engineered that.

When Dr. Stetson became the Dean at Rutgers, he had the problem of generating a faculty and also of determining where clinical facilities would be available for the clinical training of his students. He and I talked at some length in terms of the possibility of construction of a new VA hospital adjacent to his school. But we did have a hospital at Lyons, N.J. It was not as close by as we would have liked to have had it, but as he recruited his faculty they were able to immediately begin to work in our hospital. We converted research laboratories there so they could continue and further develop their research activities.

This has remained an effective, though somewhat distant affiliation. East Orange comes into the picture in relationship to the demise of Seton Hall Medical School back in 1965, I think it was, and you got in on that.

Dr. Wells. Mr. Cranston, we faced an emergency, really, at East Orange, an emergency for the New Jersey College of Medicine and Dentistry. At this particular time the medical school had lost its affiliation with the City-County Hospital. They were in desperate need of outlets for their students, and this was right during the academic year.

So we set about quickly to make resources available to them in the East Orange VA Hospital. Fortunately this was one of the older hospitals that also had a degree of flexibility in the use of its space, so that we were able to develop spaces for faculty, for research, and for student activities, in a very short time.

As a matter of fact we had classwork in progress within a little over 2 weeks, in the East Orange hospital. This involved, in addition to the things we did within the hospital, the use of 16 trailers which were pulled up on to our hospital grounds. They became very excellent laboratories and classrooms for students.

We were able, by this mechanism, to keep the school in existence, and I think to make real progress again, both for the school and for the VA hospital in East Orange.

Senator Cranston. Is it likely that many more Shreveport-type situations can develop without new sources of funding, support, and legislative authority.

Dr. Musser. We have had occasion, in the last months, to talk with representatives from a number of States; States that presently do not have schools, where additional schools are being contemplated. From them we have some indication that at this particular point in time there is a scarcity of money and thus they express a considerable concern over whether they will be able to generate locally the funds necessary to get the school started.

Senator Cranston. Dr. Musser, what do you believe, as both a professional and health care expert, is the dimension of our shortage of physicians, dentists, nurses, allied health professionals, and other health workers in terms of numbers? Is it an acute situation? Do not these shortages also, then, directly affect the VA's capacity to provide the best care?

Dr. Musser. Yes, I would say the situation is fairly acute. I would hesitate to try to accurately estimate the numbers. I think it ought to be recognized too that we have a very serious problem with maldistribution of health manpower in this country as well, but certainly a continuation of shortages of health manpower would be to the disadvantage of the Veterans' Administration, because it indeed would limit our ability to recruit all the people that we need.

Senator Cranston. Do you feel that the VA is utilizing all its available potential to train health manpower to meet the national and VA need?

Dr. Musser. No, sir. Dr. Wells and I and others in the Department have studied this, particularly in the last year and one-half or so. We feel that there is a considerable additional potential for the training of health manpower in our system that could be used in the national interest.

Senator Cranston. Is it not a fact that the VA Department of Medicine and Surgery has itself given substantial consideration to the desirability of proposing legislation such as S. 2219 and House Joint Resolution 748?

Dr. Musser. In regard to Joint Resolution 748, certainly our experience with medical schools in the past would indicate our desire to cooperate with them and make our facilities available. So in principle we are talking about 748——

Senator Cranston. House Joint Resolution 748 and S. 2219.

Dr. Musser. Yes; I am talking about House Joint Resolution 748 for the moment.

In principle this is entirely compatible with our pattern of operation. I think the position that we have taken in regard to this joint resolution relates to the extent to which Federal funding of medical education would be fragmented by virtue of a grant authority which we might be provided.

I think this is equally true of S. 2219.

Senator Cranston. But you have given substantial consideration, in your deliberations as to what to do to improve the situation, to making proposals along these general lines. Is that correct?

Dr. Musser. Yes, sir.

Senator Cranston. Have not studies been made by the VA health manpower specialists showing where, particularly, new medical schools and area health education centers could appropriately be established, and if so, what do those studies show?

Dr. MUSSER. In January of 1970, for the first time, I met with Dr. Roger Egeberg. He indicated his interest and the interest of HEW in the extent to which property located at a VA hospital might be available for involvement in the development of new medical schools. He asked at that time that we conduct a survey of our system to identify hospitals that might be particularly well suited for this purpose. I think we identified some 15 hospitals that we thought were particularly suitable for this activity. Indeed this study was made.

Senator CRANSTON. Would you indicate where that was, for the record.

Dr. MUSSER. I would be happy to submit it for the record.

(Subsequently, the Veterans' Administration submitted the following information:)

In testimony prepared for hearings before the Sub-Committee on Veterans Affairs of the Committee on Labor and Public Welfare of the United States Senate in 1966, Dr. Stafford L. Warren, Vice Chancellor of Health Sciences Emeritus, UCLA, provided a list of 31 locations in which he believed that a combination of a small city, a community hospital, a college and a Veterans' Administration hospital could join together to establish a medical school. From among this list of 31 he had identified 15 locations in which there are non-affiliated Veterans' Administration hospitals, and 6 additional ones where there are affiliated Veterans' Administration hospitals but which hospitals are some distance from their medical schools.

In the first group of 15 he included:

Montgomery, Ala.,
Erie, Pa.,
Topeka, Kans.,
Amarillo, Tex.,
Spokane, Wash.,
Fort Wayne, Ind.,
Boise, Idaho,
Fresno, Calif.,
Wilkes-Barre, Pa.,
Battle Creek, Mich.,
Fargo, N. Dak.,
Sioux Falls, S. Dak.,
Waco, Tex.,
Huntington, W. Va.,
Wilmington, Del.

The six additional sites were:

Providence, R.I.,
Alexandria, La.,
Lincoln, Nebr.,
Des Moines, Iowa,
Wichita, Kans.,
Sepulveda, Calif.

Senator CRANSTON. Have there not been similar studies of the potential of the VA to train more and new types of professional and paraprofessional health personnel, and what do these studies show?

Dr. MUSSER. At the instigation of the House Veterans' Affairs Committee, the latter part of last year, a questionnaire was sent to all VA hospitals asking what types of education and training programs they were conducting at the time, and also asking the expansion which they thought was possible in their hospitals as of September 1971, this coming September.

House Document No. 3, which was published in February, contained the reports of this survey, and it indicated that our hospitals could add an additional 13,000 students this September, if appropriate funding were available. Now, this I think is of some interest in that it indicates what magnitude of expansion was possible in just a one year period.

Now, there are other studies that have been done that in general would indicate that over time, and with appropriate modifications in our system, we might come close to doubling our annual workload of students, if you want to call it that.

Presently we have some 50,000 students in training. There are those who think this could be doubled under appropriate circumstances.

Senator CRANSTON. What were your projections after the first of the year?

Dr. MUSSER. Well, we did not carry it that far. As I said, that was a House Veterans' Affairs Committee initiated study anyhow.

Senator CRANSTON. Could you provide for the record all the Department of Medicine and Surgery studies dealing with the expansion of health manpower training and the establishment of new medical and other health personnel training schools?

Dr. MUSSER. Yes, sir.

(Subsequently, the Veterans' Administration furnished the following information:)

In his testimony, Dr. Musser used information contained in, and identified for the record, House Committee Print No. 3, printed for the use of the House Committee on Veterans' Affairs. With that Committee's permission, and as the most concise and convenient means of responding to the request of the Chairman of the Subcommittee, the attached Committee Print No. 3, together with supplemental information concerning the expansion of health manpower training and the establishment of new medical and other health personnel training schools is furnished for the record. (It is set forth in the appendix on page 427.)

SUMMARY OF EDUCATION AND TRAINING ACTIVITIES OF DEPARTMENT OF MEDICINE AND SURGERY FOR FISCAL YEAR 1971 ET SEQ

It is no longer possible to address the nation's health manpower needs in terms of total numbers for specific fields or professional disciplines. The circumstances of the economy and of the manpower market generally have created geographical variations in the availability of jobs in all fields and remarkable imbalances between demand and supply of manpower. Jobs in the allied health fields generally, particularly at the paramedical or the technical level, do not warrant the expense to the employee or to the employer of major relocation, consequently investments of dollars in health manpower training programs must be based on needs for health services as they are identified in individual communities or health service areas, concentrating attention not only on basic training but on distribution, utilization, and retention of trained personnel.

The Department of Medicine and Surgery bases its priorities for expansion of allied health training and education programs on the relevance of the individual program to demonstrated needs and support is concentrated, to the best of the system's ability, in training which will produce manpower with the appropriate capabilities and skills, and in reasonable numbers, to provide the kinds of services most seriously needed by the communities of which VA hospitals are a part.

There is virtually no area of the United States, however rural, that is served by a VA hospital that does not also include other health care and educational institutions, particularly community junior colleges and vocational schools, which have the interest and the capability to contribute to the production of health workers. Many of the health service agencies, such as community hospitals, clinics, outpatient services, and even health practitioners' offices are involved, usually unilaterally, in some phase of the preparation of health workers, with the expense added to the cost of the services provided. Small additional investments can frequently achieve the coordination of these efforts with the result of decreased educational costs and increased production of trained personnel. Because of the very unique resources of VA hospitals, even those providing specialized care or remotely located, make them ideal agencies to serve this coordinating role. In addition to the wealth of clinical material, the availability of up-to-date equipment, and at least some available education space, the employees of the DM&S facilities include the nation's largest "clinical faculty" of 25,000 allied health professionals trained at the baccalaureate level or higher and certified and/or licensed in their specific disciplines. These are in addition to the nearly 6,000 full-time physicians and dentists who also contribute to these training programs.

Within the limits of its present budget and legislative authority, the Department of Medicine and Surgery will, by the end of this fiscal year, have made possible this kind of coordination for expansion of allied health training programs in at least five selected sites:

> Through its hospital in Little Rock, Arkansas, DM&S will have provided the implementing funds for the opening of a new school of allied health professions within the University of Arkansas, as authorized by the University's Board of Trustees. The disparate and partial programs for the education and training of health workers that have existed within the Medical Center, the Medical School, the University Hospital, the undergraduate campuses in both Little Rock and Fayetteville, and some in the private hospitals in the city of Little Rock, will be coordinated and made more efficient by sharing of facilities and faculty. Class sizes will be increased so that Arkansas students, trained in Arkansas schools, may have a wide range of training opportunities in Arkansas, and therefore, will be more likely to remain to serve the needs of the state. The placement within the VA of a position for the Dean of the School and several key faculty members, each carrying appropriate faculty rank in the University, will also allow for experimentation and demonstration with improved utilization of health manpower in several new areas. A program for the training of Physician's Assistants will be created. The presence at the North Little Rock hospital of the VA's Central Research Instrument Pool, will provide the staff and the equipment for an innovative program in the training of biomedical instrument repair technicians. A special program in the preparation of professional nurses for family practice, will be initiated in cooperation with the University's School of Nursing. A new program under the joint direction of nurses and allied health personnel will prepare operating room technicians, to serve the needs of the VA hospital and of the hospitals of the state which joined together to petition the VA hospital to help provide them with a source of these much needed people. In addition to these new programs, the existing training programs will be significantly expanded by using more clinical rotations in the VA. For example, the state's only training program in nutrition and dietetics will be able to double its enrollment.
>
> Another such assignment will be made to the St. Louis, Missouri VA hospital which, in addition to the traditional services of a large medical school affiliated hospital, is a major trainer and employer of inner city ghetto residents. Its first new program is for 20 Physician's Assistants per year, in affiliation with St. Louis University, Washington University and the county Junior College System.
>
> A coordinator and at least two additional instructors have been assigned to the VA Hospital in Seattle, Washington in time to assure the careful and adequate planning of a newly authorized education building on the hospital grounds. Special attention will be given to the retraining and utilization of highly skilled scientists in the community who are presently unemployed.
>
> The presence of such a coordinator position at the VA Hospital in Durham, North Carolina established one year ago has already resulted in major expansion of that hospital's allied health training for the needs of the Piedmont area. It is expected that much of the success of this program can be translated into a similar arrangement between the VA hospital at Oteen, North Carolina and the new School of Allied Health at Western North Carolina University, to serve some of central Appalachia.

In addition to being uniquely suited to the training and utilization of new types of health professionals, such as Physician's Assistants, Dentist's Assistants, and Nurse Practitioners, the hospitals of DM&S are for the same reasons, in a position to experiment with new ways of utilizing existing personnel and personnel being trained in the more traditional disciplines.

By the end of this year twenty or more VA hospitals will be affiliated with seven academic programs for the training of Physician's Assistants. Proponents of each of the recognized systems of training of these new health personnel have come to recognize as the limiting factor to their expansion, the availability of adequately supervised clinical experience which is an integral part of each of the programs. DM&S hospitals offer an unparalleled resource for this kind of training, because of their freedom from the strictures of state licensing laws, independence of third-party-payment systems, and freedom from the constraints of professional conservatism. The VA-affiliated Physician's Assistant training programs will, by FY 1973, be producing approximately 200 graduates per year. In addition, it is expected that by that time, at least three more major affiliations will be established, each with a capacity of approximately 20 students a year, instead of 4 or 5, to which they would be limited by their own clinical facilities.

At least 10 VA hospitals are now participating in the provision of clinical experiences for Nurse Practitioners. This is particularly true in rotations in psychiatric hospitals and the psychiatric services of larger GM&S hospitals. An example of this may be found in the state of Florida, in which the VA hospitals there provide the only psychiatric facilities in the state available for nursing training at any level.

Completion late in FY 72 of a new dental education building at the VA hospital, Birmingham, Alabama, will allow for both training and practice of dental professionals and dental auxiliaries in full use of the concept of expanded function of nondentist personnel.

Because of its capability to limit the parameters of the training it offers, and supported by the standards established by the Civil Service Commission the VA-affiliated, 2-year programs for training of physician's assistants represent the only standardized experience in the nation with this category of personnel. This will enable DM&S, in cooperation with the National Center for Health Service Research and Development, to undertake the evaluation of Physician's Assistants in affecting the delivery of care in the hospitals where they are trained, and where they are employed. The evaluation will then be comparable with that being done by the military services, and by the shorter MEDEX programs which are designed explicitly to utilize discharged military corpsmen with independent duty experience.

VA hospitals have joined in two very significant demonstrations of the career ladder concept in the training of nursing personnel. Capitalizing on the excellent and flexible programs of the state system of junior colleges in California, VA hospitals in Palo Alto and Martinez are now affiliated with the De Anza and the Contra Costa Junior Colleges, respectively, to share the cost of providing almost individually designed training programs to build upon the skills of Nursing Assistants trained in community and VA hospitals, so that they may attain the next higher step on the nursing career ladder (licensed practical nurse or professional nurse) without repetitive course work and without loss of personal income. These programs are being closely watched by other community junior colleges and hospitals, and will undoubtedly serve as the basis for a rapidly increasing number of such programs around the country.

There is increasing recognition by hospitals, both the VA and community institutions, that training of health workers at the lowest level of the career ladder i.e., nursing assistants, aides, and helpers, is actually the most costly in terms of the hospital's own budget. This is because the training takes place exclusively in the hospital system, rather than being shared by the regularly financed educational system, and because of the high turnover rate of these employees. DM&S has undertaken two major programs aimed at the alleviation of this serious problem.

The Education Service has entered into a contract with the Miami-Dade Junior College (Florida), a system of three campuses serving a large and mobile urban population with excellent and innovative programming and special depth in staffing and facilities for the training in health occupations. The contract is designed to develop a process by which all of the educational and health care resources of a community can be combined to train, and adequately utilize, supportive health workers. As its second purpose, it will provide a means to improve the mobility of such personnel, both in terms of their own careers and in their utilization by employers. A curriculum will be developed and tested for use by junior colleges and vocational schools for the basic training of persons of minimal educational attainments. The intention is to provide these persons with a set of basic skills which can be readily and flexibly adapted to the special needs of hospitals, outpatient facilities, prevention and screening centers, nursing homes, home health programs, and extended care facilities; and at the same time provide a system by means of which academic credit, even if in only very minimal amounts, can be recorded for trainees who might wish eventually to move up the educational ladder.

The second of these innovative studies is being undertaken by a consortium of health care and educational institutions in southern California led initially by the Los Angeles Community College, in affiliation with the Brentwood VA hospital. Accommodated by the unique organizational arrangement of the Brentwood program, in cooperation with the flexible programming of the junior college, this program will provide an experience similar to that described in the Miami program. It is, however, designed specifically for personnel to work with patients not confined to hospital beds, but under care for mental and emotional illnesses including drug and alcohol dependence. Trainees will be carefully selected for their ability to establish rapport with these patients, particularly with Vietnam Era veterans, and for their ability to adjust to a variety of circumstances, including store-front clinics, open psychiatric wards, and in the supportive care of paraplegic and spinal cord injured patients.

Senator Cranston. In my opening statement, I stressed the uniqueness of the VA because of freedom from the strictures of State licensing laws, in terms of having a great, not fully tapped potential to be at the forefront of the training and employment of new types of health professionals, such as physicians' assistants, dentists' assistants, and nurse practitioners. Do you agree with my assessment?

Dr. Musser. Yes, sir. I might add that we have another advantage, being a Federal health system, in that we have access to the Civil Service Commission, or let us say more access to the Civil Service Commission in developing new classification standards for new types of skills.

Now, you are familiar, I think, during the past year we were able to work out with Civil Service a classification series for the physicians' assistant. This has been very helpful. It has enabled us to employ them now.

Senator Cranston. Could you describe the VA's present programs in this area, both in terms of affiliations and direct VA teaching programs, and your plans for expansion in the future? Along with that, do you include in your physicians' assistant training plans, the training of experienced head nurses to be physicians' assistants?

Dr. Musser. I will ask Dr. Wells to answer that.

Dr. Wells. Yes, sir. We are planning along that line, along with the physicians' assistant type that we get in the former corpsmen, former military corpsmen. But we are also interested in the dental assistant, nurse clinician, and her potential within the hospital system. Also the associates for social service work, the subdoctorate level of the clinical psychologist, and so on. We have quite a list of types of health manpower that we have been considering and indeed are experimenting with.

Dr. Musser. Starting this past July, in collaboration with some of the schools offering the academic courses for physicians' assistants, we have initiated clinical training programs for these students in 20 of our hospitals.

Senator Cranston. You do in effect agree that the VA has a unique opportunity here to do something of great significance in terms of training?

Dr. Musser. Very definitely.

Senator Cranston. And employment also thereafter?

Dr. Musser. Yes, sir.

Senator Cranston. What plans do you have for developing nurse practitioner training programs and for retraining and upgrading experienced registered nurses?

Dr. Musser. Dr. Wells.

Dr. Wells. I think that is two different questions. We have a very active, and we think a very effective in-service training program for nurses in order to retain their skills. We are now entering a period when we expect to have university-based additional training for nurses, particularly to help them go into such things as intensive care unit work, emergency room work, and other things that have been uncommon for the nurses in the past.

The matter of getting nurses involved as physicians' assistants has been complicated somewhat by the reluctance on the part of the American Nurses Association and certain other organizations to go into this. We do have now a few schools of nursing where they are interested in this, and we are indicating our willingness to supply the clinical resources for this training.

Senator CRANSTON. What is your view about what can be done, as these programs with physicians' assistants prove successful in the VA hospitals, to change the regulations of laws and licensing procedures so there will be opportunities for them to work elsewhere?

Dr. MUSSER. This already has happened to a large extent. Dr. Anlyan is in the audience, and he is intimately aware of the effort that Duke University made to get recognition for the physician's assistant and to work out legal mechanisms that would enable them to serve practicing physicians in, not only North Carolina, but in other parts of the country. To a large extent a fair number of legal obstacles have already been overcome.

Senator CRANSTON. Some of the legal obstacles have been overcome but certain other obstacles have not. In California a law was passed last year, but implementation was left to the board of medical examiners, and not too much has happened as a result of their negativism.

Dr. MUSSER. We would like to think that we have the capability in our system to study how best the physician's assistant might be used and have this become a demonstration of sorts, if indeed others would like to adopt it. We think we have this experimental capability that ought to be utilized.

Senator CRANSTON. We have to get the word out to find a way to achieve effective application of this in the community.

What is your program for the upgrading and continuing education of your nursing personnel in order to provide career advancement opportunities for nursing assistance and aides, licensed vocational nurses, and registered nurses?

Dr. MUSSER. As Dr. Wells mentioned, I think in each of our hospitals there is an in-service continuing education program for nursing personnel. In addition to that we do try to encourage nursing assistants and all registered nurses to go to school and to take courses that might qualify them for further advancement.

We currently have been working on a program that would enable us to identify equivalency attainments. These are skills that would be comparable to academic experience. As we do this, I think we will be able to work into our system mechanisms for career development that heretofore have not been possible.

Dr. WELLS. I might extend this just a bit, Mr. Chairman. We are now, really for the first time, working very closely with the National Association of Junior Colleges, community colleges, in the development of programs specifically designed for the nursing assistant and the licensed vocational nurse.

Our first major project along this line is at Little Rock, Ark. We have at least three others that are in the process of development at the present time. This would allow upward mobility of the nursing assistant and of licensed vocational nurses.

Senator Cranston. Do you have a high turnover rate at the nursing assistant level and other levels lower down the ladder?

Dr. Musser. Quite high.

Senator Cranston. That is where a lot of disadvantaged people are employed. Is that why there is a high turnover rate?

Dr. Musser. I think they continue to look for better jobs and as these become available they take them. Our greatest mobility is at this lower level of salary.

Senator Cranston. What sort of upgrading and upward mobility programs are there for other health workers such as technicians and paraprofessional personnel?

Dr. Musser. Medical technicians can move up in the classified levels, whereas without some opportunity for continuing education, there is a very fixed point beyond which the nursing assistant has not been able to go. Only as they qualify by virtue of additional education.

Senator Cranston. Are they encouraged to get this additional education?

Dr. Musser. This is what Dr. Wells was talking about in terms of the program we initiated at Little Rock whereby we will be able to send our own employees to schools in the community college.

Senator Cranston. That is needed in many other places, isn't it?

Dr. Musser. Definitely.

Senator Cranston. Would you not have greater flexibility, both to compete for personnel and to establish more complete career advancement programs, if all your health care personnel were under the Department of Medicine and Surgery?

Dr. Wells. This has been a moot question for many years, Mr. Chairman. We certainly think that title 38 proved its value in 1946 as far as the dentist, nurse, and physician was concerned. We know that we have much greater hiring capacity, hiring flexibility under title 38. We can accomplish this in a much shorter time. There is a great flexibility in fitting the type of person that you want to a grade level that will be what he should get for his skills, rather than simply staying with the job description. We think this is an extremely important advantage.

Over the years we have the threat over us that if title 38 were extended to many other categories within the Department of Medicine and Surgery, that we might lose this advantage. I think quite frankly there has been a tendency to rather jealously guard the advantage that we presently have as opposed to trying to seek an improved or expanded advantage under title 38.

Senator Cranston. What kind of threat and from whom are you referring to?

Dr. Wells. The Civil Service Commission and the Bureau of the Budget.

Dr. Musser. Actually, as we have examined this, we have had some occasion to question whether the involvement of all Department of Medicine and Surgery employees in title 38 would be a manageable activity. Certainly for the doctors and dentists and nurses, flexibility as Dr. Wells described, has been helpful. I am not sure we need that degree of flexibility in all the other types of health workers we employ.

Senator Cranston. Isn't it advisable to create maximum opportunities for mobility and develop the concept of a team approach to rendering medical care and not have a lot of different systems with different hierarchies that could have a damaging effect on the effectiveness of the system?

Dr. MUSSER. That is true. Certainly we would like to think that there can eventually be maximum mobility. On the other hand I think that we have approached this from the educational standpoint, that there are provisions within the civil service classified system that would enable us to do this.

Senator CRANSTON. Are VA salaries adequately competitive with community and university hospitals for most health care personnel?

Dr. MUSSER. Yes; I think you might say for almost all health care personnel except physicians. Now I said "almost" because I am aware of certain categories of health worker like, for instance, radiology technicians. In some places we have trouble maintaining competitive positions. But in general we do well.

Now we are aware that there is some disparity in our physicians' salaries.

Senator CRANSTON. You do have some problems in certain urban areas in competing for various types of professionals, do you not, and also don't you have some difficulty in getting professionals to accept assignment at remote VA hospitals?

Dr. MUSSER. You are talking of all professionals or physicians?

Senator CRANSTON. Physicians and certain other types where there is some scarcity.

Dr. MUSSER. Yes. In some remote areas not only do you find that there is reluctance on the part of some to go there, but within those regions there are just not as many of these people available so that you are limited in terms of numbers and in terms of the attractiveness of the locality.

Senator CRANSTON. What is your program for continuing medical and dental education in the VA Department of Medicine and Surgery?

Dr. WELLS. Our continuing education program, Mr. Chairman, has been handled under what we call postgraduate in-service training over the years. It has consisted of short periods of leave for formal course work under various auspices and some longer periods of leave for special opportunities to even do research as well as to enter into training.

We are able to send very large numbers of our physicians—not nearly as many of the other professionals—each year to some kind of training opportunity. Some of these are very limited; simply such things as the course work offered by the American College of Physicians and Surgeons, and so on. But it is a fairly extensive program of continuing education on a broad basis for our own people.

Senator CRANSTON. Is this working to its maximum potential?

Dr. WELLS. I would say, no, it is not, simply because in order to accomplish anything like maximum, we would have to have longer periods of training. We would have to have some additional formalization of this in centers and we would simply have to send more people than we do at the present time. Our rate is not that great.

Senator CRANSTON. Do you have difficulty in convincing OMB of the need for funding?

Dr. WELLS. We have not prospered as well sometimes as we would like in this postgraduate and in-service training.

Senator **Cranston.** Dr. Musser, as a physician, do you find it difficult to make decisions not to treat certain sick persons because they don't fit into certain legislative pigeon holes for nonservice-connected treatment?

Dr. **Musser.** Would you be kind enough to clarify that?

Senator **Cranston.** As a physician don't you find it difficult to sometimes turn away somebody because there is some bureaucratic or legislative definition that excludes that particular ill person who needs help? Do you find it difficult to turn him away because he has a nonservice-connected disability?

Dr. **Musser.** You are thinking of eligibility?

Senator **Cranston.** Yes.

Dr. **Musser.** Well certainly if you approach this entirely from the standpoint of the professional issues, then you would have to say that all sick people should have the opportunity to be cared for. On the other hand we recognize that the VA has been developed pretty much on the basis of congressional legislation, that the Congress in its wisdom has decided who should be eligible for care and what the criteria were, and we try our best to carry out the laws as they have been enacted. There are two sides to the issue, I think.

Senator **Cranston.** Maybe Congress can develop some new wisdom on the subject. Do you have any comments?

Dr. **Wells.** I would say we are particularly embarrassed at times, by reason of not being able to handle on an outpatient or ambulatory basis, the type of patient that we think could much more efficiently and much more in the patient's interest be handled in that modality. This has been true in the psychiatric area, as psychiatric treatment in this country has moved to the ambulatory rather than inhospital treatment. At this point we have encountered difficulties that relate to the existing legislation.

Senator **Cranston.** I assume that these problems become even more intense to a doctor who is there, not in an administrative capacity, but actually practicing health care. What do these difficulties do in terms of their effect on the VA medical care system?

Dr. **Musser.** Certainly in terms of this ambulatory care problem—and fortunately there is legislation here that if enacted will go a long way toward correcting that—it becomes a source of discouragement to some of our physicians who find that a veteran does not qualify or is not ill enough to be hospitalized and yet he needs certain things which under current law cannot be provided.

This has been an increasing problem which we hope this legislation will correct.

Senator **Cranston.** Do you receive from physicians and medical schools many complaints about the non-service-connected treatment limitations? For example, the feeling that such distinctions are irrelevant from a treatment point of view.

Dr. **Musser.** We receive some, but not a great many. I think that most of our affiliated schools clearly understand the preference that the service-connected veteran has. I have never heard anyone disagree with it.

Again I think that the majority of our problem now relates to this restriction of ambulatory care.

Senator **Cranston.** Can you explain the basic difference in effect in operation—besides the need for greater paperwork—between the administration-proposed expansion of outpatient care for nonservice connected conditions in S. 1924, to include care when reasonably necessary to prevent hospitalization—a standard incidentally I suggested in March 1970—and the standard in my bill, S. 2354, opening up such care based on sound medical judgment and eliminating the artificial categories of prehospital care, posthospital care and preventive care?

Dr. WELLS. Well, the mechanism of handling patients on a prehospital care basis, for example, produces quite a bit of a problem, because it presumes that hospitalization has already been determined as essential. Therefore it eliminates certain categories of patients who may not need hospitalization at all, but this is the only basis on which they could be handled, on a prehospital basis.

The multiple categories have tended to fragment and confuse care from time to time. I think that Dr. Musser and I would agree that if this were left simply to the best judgment of the physician, to determine what kind of care the patient needed, whether it be outpatient care, hospital care, nursing home or extended care, and so on down the line, that we would serve the patients' interests much better.

Dr. MUSSER. As we have discussed, we have questioned whether it is indeed possible to legislate medical care in terms of what it should be. We think that it is entirely possible to determine legislatively who should be eligible for care, and yet we think that what nature of care is to be provided and how it should be provided ought to be a professional decision.

Senator CRANSTON. I gather from your responses you don't see any great difference between the two approaches?

Dr. MUSSER. Not much. On the other hand, if indeed we have an expanded authority for ambulatory care, it will help us to simplify our paperwork a great deal, because then we will move to a single record whereas now we have dual records, one for in- and one for outpatients. Our paperwork would be simplified.

Senator CRANSTON. That is a major objective I had in mind. Is there any significant difference in the cost between the two approaches?

Dr. MUSSER. Not to my knowledge.

Senator CRANSTON. Paperwork has cost, however.

Dr. MUSSER. Yes; and of course it will depend a lot on our ultimate experience, but we believe that our ability to treat more patients on an ambulatory basis ought to save us money and be less costly than hospitalization.

Senator CRANSTON. Assuming you are familiar with the Carnegie Commission Report on Higher Education and the Nation's Health, has the VA prepared any comments on the Commission's recommendations, particularly as they relate to the potential of VA hospitals to form the basis for new medical schools or area health education centers?

Dr. MUSSER. Yes; we have done a great deal of that. Some on our own and a good deal in conjunction with representatives from the Health Services and Mental Health Administration of HEW, and also the Bureau of Health Manpower. We have approached this, not only from the standpoint of involvement of VA hospitals in so-called health centers and medical schools, but particularly from the standpoint of area education centers.

In introducing the concept of area health education centers, the Carnegie Commission on Higher Education recommended the development of consortia or other special cooperative arrangements among educational and health care institutions in communities not presently served by medical schools or major medical centers, for the purpose of strengthening the expanding health manpower programs and thereby increasing the quality and availability of health care.

The commission identified 16 such communities in which they believe that the VA hospital is the institution most immediately capable of serving as a focal point for an area health education center. The Department of Medicine and Surgery made a subsequent assessment of its unaffiliated hospitals and identified eight which have unusual potential in terms of both the resources of the hospital itself and the community in which it is located.

Visits to these eight communities were arranged and included representatives from the Bureau of Health Manpower (NIH) and the Health Services and Mental Health Administration of DHEW as well as representatives of the VA central office. It was the purpose of these visits to identify interests and capabilities, in the VA hospitals and in the communities, to work together to achieve the goals of area health education centers; and to match the potential for community projects with appropriate funding resources at the Federal level. The visits have been completed and the findings on the individual communities compared with one another. Depending on the availability of funds, it is very likely that the VA will initiate, by means of its characteristically flexible funding capability, the establishment of area health education centers in at least five of these areas. This will open opportunities for further planning and with interagency funding.

Early progress in area health education centers will be based almost exclusively on increased production of allied health manpower to meet local health service requirements. In this way the Department of Medicine and Surgery's investment here will be complementary to the investment in the coordination of allied health training, as illustrated in Little Rock, St. Louis, Seattle, and Durham.

Senator CRANSTON. What are your personal professional views on the Carnegie Commission recommendation?

Dr. MUSSER. I think that a good deal of what it says has been written before. But I think it came along at a time when there was more than the usual amount of confusion in the medical community, and it has helped a good deal to provide some kind of a basic document which has helped eliminate confusion. It has been something that people could understand, and it made sense, and it has been helpful in this regard.

Senator CRANSTON. Do you have any comments, Dr. Wells?

Dr. WELLS. I think the general concept of the 126 area health education centers is a very sound one. It emphasizes regionalization for the better utilization of existing facilities and better utilization of health manpower. So that I think that in the last analysis it is calculated to give us a better form of health care at a lower cost.

Therefore, I think it is a substantial contribution. I might say I was a bit disappointed in their comments relative to biomedical research. Although I realize that we are in an era when we cannot think in terms of the exponential type of growth we had in the early 1960's, still I am a little disturbed at their suggestion that this be tied entirely to the advancement of the gross national product. It seems to me this is something of a stricture that might prove to be difficult to live with over the years.

Senator CRANSTON. I think GNP is a false guide. I think we should not make policy judgments based on GNP factors.

What limitations do you believe the rather restrictive nature of the VA eligible veteran patient load places on the capability of the VA to provide good health manpower training opportunities?

Dr. MUSSER. Well, of course we have long recognized the fact that we treat mainly males has been a limitation. Let us go back to Shreveport. They have arrangements with the community hospital, the Confederate Memorial Hospital, where there is a broad range of patients of both sexes and ages, therefore training in pediatrics and in female medicine is made available. If these joint arrangements can be made, I think this overcomes what otherwise would be rather serious disadvantages of the limitation of our patient population.

Senator CRANSTON. We will set forth in the record at this point appropriate excerpts from the Carnegie Commission Report and materials relating to the Veterans' Administration activities relevant to the commission's recommendations.

(The information subsequently supplied follows:)

EXCERPTS FROM CARNEGIE COMMISSION REPORT

THE LOCATION OF NEW UNIVERSITY HEALTH SCIENCE CENTERS

The Commission believes that there should be a university health science center in every metropolitan area with a population of 350,000 or more, except for those areas which can benefit from the impact of centers that already exist in other geographically convenient communities. The Commission has identified eight metropolitan areas of at least this size and an additional metropolitan area, Duluth-Superior, with a population falling somewhat below 350,000, in which we believe university health science centers should be established (Table 4). Duluth-Superior is located so far away from the nearest medical school (in Minneapolis-St. Paul) that its needs cannot be adequately served without a university health science center of its own. Moreover, a university health science center in the Duluth-Superior area would serve large parts of northern Minnesota, Wisconsin, and Michigan.

TABLE 4.—CARNEGIE COMMISSION GOALS FOR NEW UNIVERSITY HEALTH SCIENCE CENTERS BY 1980

[Not including medical schools in development in 1970]

Standard metropolitan area	Estimated population, July 1, 1967 (in thousands)	Percentage increase in population, 1960–67
Phoenix, Ariz	859	29.5
Norfolk-Portsmouth, Va	646	11.7
Springfield-Chicopee-Holyoke, Mass.[1]	557	4.6
Jacksonville, Fla	505	10.8
Wilmington, Del.-N.J.-Md	481	16.0
Tulsa, Okla	451	7.8
Fresno, Calif	416	13.6
Wichita, Kans	396	3.7
Duluth-Superior, Minn.-Wis	273	−1.4

[1] Metropolitan state economic area.

Source: U.S. Bureau of the Census, Current Population Survey: Population Estimates, ser. P–25, No. 411, Washington, D.C., 1968; and American Medical Association, Medical Education in the United States, 1968–69, Chicago, 1969. Information on medical schools that have begun development since publication of the latter volume has been supplied by the Council on Medical Education of the AMA.

Not included in Table 4 are 27 communities, many of them with a population of 350,000 or more, that have medical schools in the development stage. These developing schools are included, along with existing university health science centers and recommended new health science centers, on Map 1 and in Appendix B, Table 1.

The Commission recognizes that plans are being formulated for new medical schools in some of the communities in Table 4 as well as in other communities not included. However, we believe that, for communities with populations below 350,000, the area health education centers suggested in the following section would be a more appropriate solution.

The Commission also recognizes that local initiative is desirable, and usually essential, in planning for a new university health science center. In the absence of local initiative, it may be difficult to develop centers in the nine communities we have identified.

The Commission recommends the development of nine new university health science centers

THE ROLE OF AREA HEALTH EDUCATION CENTERS

In some parts of the country the distances between university health science centers are likely to be very great, as in the sparsely populated mountain states. Elsewhere, concentration of people in congested urban areas would overwhelm the facilities of even the largest health science center. In both types of areas there should be "area health education centers," which would provide facilities for patient care, often on a referral basis from surrounding areas; educational programs for house officers and, to some extent, for M.D. candidates who could rotate through an area health education center from a university health science center; clinical experience for allied health students; and continuing education programs for health manpower.

These area health education centers, in essence, would be satellites of the university health science centers and would be visited on a regular basis by the faculty of the health science centers with which they were affiliated. Their educational programs would be developed and supervised by the health science faculty, and their patient care functions would rely on the expertise of the health science center personnel. The area centers in turn would provide assistance and counsel to the community and neighborhood health care facilities, including the private practitioner.

There are examples of existing institutions, including the Mary I. Bassett Hospital in Cooperstown, New York, which are serving such functions in their areas. In a somewhat different category is the Mayo Clinic in Rochester, Minnesota, if only because its reputation is such as to draw referral patients from all over the country. It trains about 700 residents in every specialty, is affiliated with the University of Minnesota Medical Center, and is developing plans for an M.D.-candidate program.

There are other examples of cooperative efforts to raise the quality of care in areas remote from university health science centers. These include Bingham Associates, centered in Boston, but carrying out field work throughout Maine; the Duke Foundation, which has funded a program to improve the quality of care in rural hospitals in North Carolina and South Carolina for 35 to 40 years; and a system of cooperative hospitals in the state of Wisconsin.

The nucleus of an area health education center would be a hospital, usually a community hospital, but perhaps in some cases a Veterans' Administration hospital. The house officers at the hospital would receive instruction from the faculty of the medical school with which the center was affiliated, in most cases on a visiting basis, but there would be a need for a small group of faculty members permanently located in the center to plan and administer both the educational programs for the house officers and continuing education programs for physicians and other health workers in the surrounding area. M.D. and D.D.S. candidates would receive part of their clinical instruction in such centers on a rotating basis. Within the hospital, or adjacent to it, there would have to be office space for faculty members and other administrators of the educational programs as well as classrooms. Like the university health science centers, the area centers should cooperate with comprehensive colleges and community colleges in the area in planning curricula for allied health workers.

The functions of area health education centers would be as follows:

1. To maintain a community hospital of outstanding quality, many of whose patients would be admitted on a referral basis from smaller communities in the surrounding area;
2. To conduct educational programs under the supervision of the faculty of the university health science center with which the area center is affiliated;
3. To have these educational programs include:
    - a. Residency programs,
    - b. Clinical instruction for M.D. candidates and D.D.S. candidates who would come there from the university health science center on a rotating basis,
    - c. Clinical experience for students in allied health programs,
    - d. Continuing education programs for health manpower in the area, conducted in cooperation with local professional associations.
4. To provide guidance to comprehensive colleges and community colleges in the area in the development of training programs for allied health professions;
5. To cooperate with hospitals and community agencies in the planning and development of more effective health care delivery systems;
6. To conduct limited research programs concerned primarily with the evaluation of health care delivery systems.

In some of the sparsely settled states, area health education centers would have to be affiliated with university health science centers in neighboring states with larger populations. These arrangements should be worked out on a regional basis, as suggested below in the section on regional planning.

The Commission recommends the development of area health education centers in areas at some distance from university health science centers which do not have sufficiently large populations to support university health science centers of their own, and in a few metropolitan areas needing additional training facilities but not full health science centers. These area centers would be affiliated with the nearest appropriate university health science center and would perform somewhat the same functions recommended for university health science centers, except that the education of M.D. and D.D.S. candidates would be restricted to a limited amount of clinical education on a rotational basis, and research programs would be largely restricted to the evaluation of local experiments in health care delivery systems.

THE LOCATION OF AREA HEALTH EDUCATION CENTERS

In developing its suggestions for the location of area health education centers, the Commission has carefully considered the following criteria: (1) distance from an existing university health science center, a developing center, or a recommended new health science center; (2) the population of the community and its surrounding area; and (3) the objective of providing for enough area centers so that no portion of a state or region would be remote from such a center. Nevertheless, in sparsely populated states the centers would inevitably have to be farther apart than in more thickly populated states.

The Commission believes that the final selection of locations for area health education centers should be based on careful regional planning. We are therefore *suggesting* the locations indicated by our analysis but are not firmly *recommending* them. However, we believe that the number of centers indicated by our analysis is probably quite close to the number that would be needed to provide adequate geographic distribution of such centers.

In addition to the criterion of geographic distribution, we have also applied a criterion of at least one university health science center or area health education center for every 1,500,000 persons in the larger metropolitan areas. On this basis, we are recommending the development of five area health education centers in the Los Angeles metropolitan area, one in the San Francisco-Oakland metropolitan area (in the East Bay), two in Detroit, one in Pittsburgh, and one in the New York metropolitan area.

The Commission is suggesting, in all, 126 locations for new area health education centers, indicated on Map 2 and listed in Appendix B, Table 1. The appendix table indicates where there is a Veterans' Administration (V.A.) hospital that is not affiliated with a medical school in a community for which an area health education center is suggested. However, the Commission does not believe V.A. hospitals would be appropriate as nuclei for area health education centers unless their policies were changed to permit the admission of patients of all types

instead of veterans only. Under present policies, their patients are almost exclusively male and tend to be older persons suffering from long-term disabilities.

As the population grows and the centers develop, there may well be a case for converting some of these proposed area health education centers into university health science centers in the future.

We estimate that, if our recommendations for new university health science centers and suggestions for area health education centers are carried out, by 1980 about 95 percent of the population will be within no more than an hour's traveling time from a university health science center or an area health education center.

The Commission recommends the development of 126 new area health education centers, to be located on the basis of careful regional planning.

APPENDIX B: TABLES

TABLE 1.—UNIVERSITY HEALTH SCIENCE CENTERS AND CARNEGIE COMMISSION GOALS FOR NEW UNIVERSITY HEALTH SCIENCE CENTERS AND AREA HEALTH EDUCATION CENTERS BY 1980, BY STATE

State, city, and institution	Enrollment		Population
	M.D. candidates	Total	
Alabama:			
Birmingham: Medical College of Alabama	339	840	[1] 735, 500
Mobile: University health science center (developing)			[1] 383, 200
Dothan: Suggested area health education center			[2] 31, 440
Huntsville: Suggested area health education center			[2] 72, 365
Montgomery: Suggested area health education center (VA hospital)			[2] 134, 393
Alaska:			
Anchorage: Suggested area health education center			[2] 44, 237
Fairbanks: Suggested area health education center			[2] 13, 311
Arizona:			
Tucson: University of Arizona	63	79	[2] 212, 892
Phoenix: Recommended new university health science center			[1] 858, 900
Flagstaff: Suggested area health education center			[2] 18, 214
Arkansas:			
Little Rock: University of Arkansas	395	723	[1] 318, 800
El Dorado: Suggested area health education center			[2] 25, 292
Fort Smith: Suggested area health educaiton center			[2] 52, 991
California:			
Davis: University of California	48	290	[2] 8, 910
Irvine: University of California	262	580	[1] 1, 231, 200
Loma Linda: Loma Linda University	357	604	[2] 2, 000
Los Angeles:			
University of California	389	1, 993	[1] 6, 857, 200
University of Southern California	289	1, 474	[1] 6, 857, 200
Palto Alto: Stanford University	327	927	[1] 959, 200
San Diego: University of California	47	230	[1] 1, 198, 100
San Francisco: University of California	523	1, 818	[1] 3, 009, 100
Fresno: Recommended new university health science center (VA hospital)			[1] 415, 700
Bakersfield: Suggested area health education center			[1] 327, 300
Redding: Suggested area health education center			[2] 12, 773
Santa Rosa: Suggested area health education center			[2] 31, 027
Los Angeles: Five suggested area health education centers (VA hospital)			[1] 6, 857, 200
San Bernardino: Suggested area health education center			[1] 1, 085, 900
San Francisco-Oakland: Suggested area health education center (East Bay area)			[1] 3, 009, 100
Colorado:			
Denver: University of Colorado	360	982	[1] 1, 089, 800
Grand Junction: Suggested area health education center			[2] 18, 694
Pueblo: Suggested area health education center			[2] 91, 181
Connecticut:			
Hartford: University of Connecticut	32	56	[1] 793, 400
New Haven: Yale University	347	848	[1] 721, 200
Bridgeport: Suggested area health education center			[1] 772, 700
Waterbury: Suggested area health education center			[2] 107, 130
Delaware: Wilmington: Recommended university health science center			[1] 481, 000
District of Columbia:			
Georgetown University	464	943	[1] 2, 704, 100
George Washington University	414	890	[1] 2, 704, 100
Howard University	393	899	[1] 2, 704, 100
Florida:			
Gainesville: University of Florida	246	622	[2] 29, 701
Miami: University of Miami	332	982	[1] 1, 114, 000
Tallahassee: Florida State University (developing)			[2] 48, 237
Tampa: University of South Florida (developing fall 1971)			[1] 891, 000
Jacksonville: Recommended new university health science center			[1] 504, 600
Orlando: Suggested area health education center			[1] 383, 900

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State, city, and institution	Enrollment: M.D. candidates	Enrollment: Total	Population
Georgia:			
Atlanta: Emory University	293	1,018	[1] 1,288,500
Augusta: Medical College of Georgia	392	615	[2] 70,626
Columbus: Suggested area health education center			[2] 116,779
Macon: Suggested area health education center			[2] 69,764
Savannah: Suggested area health education center			[2] 149,245
Hawaii:			
Honolulu: University of Hawaii (2-year school)	59	191	[1] 619,500
Hilo: Suggested area health education center			[2] 25,966
Idaho:			
Boise: Suggested area health education center (VA hospital)			[2] 34,481
Pocatello: Suggested area health education center			[2] 28,534
Illinois:			
Chicago:			
Chicago Medical School	294	413	[1] 6,770,700
University of Chicago	289	939	[1] 6,770,700
University of Illinois	793	1,490	[1] 6,770,700
Chicago College of Osteopathy	301		[1] 6,770,700
Northwestern University	547	1,546	[1] 6,770,700
Loyola-Stritch School of Medicine	383	608	[1] 6,770,700
Rush Medical College (developing)			[1] 6,770,700
Carbondale-Springfield: University of Southern Illinois (developing)			[2] 97,941
Peoria: University of Illinois (developing)			[2] 103,162
Rockford: University of Illinois (developing)			[2] 126,706
Champaign Urbana: Suggested area health education center			[2] 76,877
East St. Louis: Suggested area health education center			[2] 81,712
Indiana:			
Indianapolis: Indiana University	857	1,857	[1] 1,041,600
Evansville: Suggested area health education center			[2] 141,543
Fort Wayne: Suggested area health education center (VA hospital)			[2] 161,776
Gary: Suggested area health education center			[1] 602,800
South Bend: Suggested area health education center			[1] 271,400
Terre Haute: Suggested area health education center			[2] 72,500
Iowa:			
Des Moines: College of Osteopathic Medicine and Surgery	348	----------	[2] 208,982
Iowa City: University of Iowa	494	1,311	[2] 33,443
Davenport: Suggested area health education center			[1] 358,100
Sioux City: Suggested area health education center			[2] 89,159
Waterloo: Suggested area health education center			[2] 71,755
Kansas:			
Kansas City: University of Kansas	483	932	[1] 1,214,400
Wichita: Recommended new university health science center	395	600	[1] 395,600
Dodge City: Suggested area health education center			[2] 13,520
Salina: Suggested area health education center			[2] 43,202
Topeka: Suggested area health education center (VA hospital)			[2] 119,484
Kentucky:			
Lexington: University of Kentucky	300	674	[2] 62,810
Louisville: University of Lousiville	367	761	[1] 795,000
Ashland: Suggested area health education center			[2] 31,283
Paducah: Suggested area health education center			[2] 34,479
Louisiana:			
New Orleans:			
Louisiana State University	510	830	[1] 1,059,100
Tulane University	506	1,015	[1] 1,059,100
Shreveport: Louisiana State University, Shreveport School of Medicine (developing fall 1969)			[1] 288,300
Lake Charles: Suggested area health education center			[2] 63,392
Maine:			
Bangor: Suggested area health education center			[2] 38,912
Presque Isle: Suggested area health education center			[2] 12,886
Portland: Suggested area health education center			[2] 72,566
Maryland:			
Baltimore:			
Johns Hopkins University	373	1,046	1,990,000
University of Maryland	521	941	1,990,000
Cumberland: Suggested area health education center			[1] 33,415
Hagerstown: Suggested area health education center			[2] 36,660
Massachusetts:			
Boston:			
Boston University	306	880	[1] 3,249,800
Harvard Medical School	577	[2] 577	[1] 3,249,800
Tufts University	458	1,044	[1] 3,249,800
orcester: University of Massachusetts School of Medicine (developing fall 1970)			[1] 618,800
Springfield: Recommended new university health science center			[1] 557,109
Pittsfield: Suggested area health education center			[2] 57,870

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State, city, and institution	Enrollment: M.D. candidates	Enrollment: Total	Population
Michigan:			
Ann Arbor: University of Michigan	807	2,601	[2] 67,340
Detroit: Wayne State University	531	1,161	[1] 4,113,600
East Lansing: Michigan State University	78	462	[1] 353,500
Pontiac: Michigan College of Osteopathic Medicine	20		[2] 82,233
Detroit: 2 suggested area health education centers			[1] 4,113,600
Flint: Suggested area health education center			[1] 476,800
Grand Rapids: Suggested area health education center			[1] 514,300
Kalamazoo: Suggested area health education center			[2] 82,089
Saginaw: Suggested area health education center (V.A. hospital)			[2] 98,265
Minnesota:			
Minneapolis: Universtiy of Minnesota	685	2,281	[1] 1,636,200
Duluth-Superior: Recommended new university health science center			[1] 272,600
Rochester: Mayo Clinic—existing area health education center			[2] 40,663
St. Cloud: Suggested area health education center			[2] 33,815
Mississippi:			
Jackson: University of Mississippi	319	587	[2] 144,422
Biloxi: Suggested area health education center (V.A. hospital)			[2] 44,053
Greenville: Suggested area health education center			[2] 41,502
Tupelo: Suggested area health education center			[2] 17,221
Missouri:			
Columbia: University of Missouri	358	1,079	[2] 36,650
Kansas City:			
University of Missouri, Kansas City School of Medicine (developing fall 1971)	0	0	[1] 1,214,400
Kansas City College of Osteopathy and Surgery	446		[1] 1,214,400
Kirksville: Kirksville College of Osteopathy and Surgery	421		[2] 13,123
St. Louis:			
St. Louis University	461	781	[1] 2,311,400
Washington University	359	871	[1] 2,311,400
Springfield: Suggested area health education center			[2] 95,865
Montana:			
Billings: Suggested area health education center			[2] 52,851
Butte: Suggested area health education center			[2] 27,877
Miles City: Suggested area health education center (VA hospital)			[2] 9,665
Nebraska:			
Omaha:			
Creighton University	302	423	[1] 514,600
University of Nebraska	365	602	[1] 514,600
Grand Island: Suggested area health education center (VA hospital)			[2] 25,742
Lincoln: Suggested area health education center (VA hospital)			[2] 128,521
North Platte: Suggested area health education center			[2] 17,184
Nevada:			
Reno: University of Nevada (developing fall 1971) (VA hospital)			[2] 51,470
Las Vegas: Suggested area health education center			[2] 64,405
New Hampshire:			
Hanover: Dartmouth Medical School (2-year school)	100	224	[2] 5,649
Berlin: Suggested area health education center			[2] 17,821
Manchester: Suggested area health education center			[2] 88,282
New Jersey:			
Jersey City: New Jersey College of Medicine and Dentistry	306	536	[1] 620,000
New Brunswick: Rutgers Medical School (2-year school)	30	61	[2] 40,139
Newark: New Jersey College of Medicine (campus under construction)			[1] 1,888,500
Atlantic City: Suggested area health education center			[2] 59,544
Camden: Suggested area health education center			[2] 117,159
Patterson-Clifton-Passaic: Suggested area health education center			[1] 1,341,000
Trenton: Suggested area health education center			[2] 114,167
New Mexico:			
Albuquerque: University of New Mexico School of Medicine	97	202	[2] 201,189
Gallup: Suggested area health education center			[2] 14,089
Roswell: Suggested area health education center			[2] 39,593
New York:			
Albany: Albany Medical College	284	997	[1] 710,200
Brooklyn: State University of New York	770	1,471	[1] 11,555,900
Buffalo: State University of New York	407	1,355	[1] 1,331,600
New York City:			
Cornell University Medical College	353	826	[1] 11,555,900
Albert Einstein College of Medicine	402	1,204	[1] 11,555,900
Columbia University	499	1,612	[1] 11,555,900
Mount Sinai School of Medicine	59	2,003	[1] 11,555,900
New York Medical College	495	944	[1] 11,555,900
New York University	514	1,209	[1] 11,555,900
Rochester: University of Rochester	308	809	[1] 838,900
Syracuse: State University of New York	399	786	[1] 619,100
Stony Brook: State University of New York (developing fall 1971)	0	0	[2] 3,548
Cooperstown: Mary I. Bassett Hospital—existing area health education center			[2] 2,553
Binghamton: Suggested area health education center			[1] 301,100
New York City: Suggested area health education center			[1] 11,555,900
Utica: Suggested area health education center			[1] 349,500

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State, city, and institution	Enrollment		Population
	M.D. candidates	Total	
North Carolina:			
Chapel Hill: University of North Carolina	287	1,080	[2] 12,573
Durham: Duke University	333	1,023	[2] 78,302
Winston-Salem: Bowman-Gray School of Medicine	226	437	[1] 582,000
Greenville: East Carolina University (developing)			[2] 22,860
Asheville: Suggested area health education center			[2] 60,192
Charlotte: Suggested area health education center			[1] 378,000
Wilmington: Suggested area health education center			[2] 44,013
North Dakota:			
Grand Forks: University of North Dakota (2-year school)	98	276	[2] 34,451
Fargo: Suggested area health education center (VA hospital)			[2] 46,662
Minot: Suggested area health education center			[2] 30,604
Ohio:			
Cincinnati: University of Cincinnati	407	882	[1] 1,361,000
Cleveland: Case Western Reserve University	374	1,391	[1] 2,050,100
Columbus: Ohio State University	611	2,262	[1] 859,600
Toledo: Medical College of Ohio (developing fall 1969)	0	0	[1] 670,700
Akron: Suggested area health education center			[1] 660,000
Dayton: Suggested area health education center			[1] 820,400
Lima: Suggested area health education center			[2] 51,037
Mansfield: Suggested area health education center			[2] 47,325
Youngstown-Warren: Suggested area health education center			[1] 525,400
Oklahoma:			
Oklahoma City: University of Oklahoma	418	997	[1] 597,900
Tulsa: Recommended new university health science center			[1] 451,400
Enid: Suggested area health education center			[2] 38,859
Lawton: Suggested area health education center			[2] 61,697
Oregon:			
Portland: University of Oregon	351	846	[1] 933,300
Eugene: Suggested area health education center			[2] 50,977
Medford: Suggested area health education center			[2] 24,425
Pennsylvania:			
Hershey: Pennsylvania State University	88	104	[2] 6,851
Philadelphia:			
Hahnemann Medical College	432	731	[1] 4,774,400
Jefferson Medical College	717	1,093	[1] 4,774,400
Temple University	552	887	[1] 4,774,400
University of Pennsylvania	520	1,380	[1] 4,774,400
Woman's Medical College	237	342	[1] 4,774,400
Philadelphia College of Osteopathic Medicine	461		[1] 4,774,400
Pittsburgh: University of Pittsburgh	388	924	[1] 2,386,100
Allentown-Bethlehem-Easton: Suggested area health education center			[1] 525,500
Altoona: Suggested area health education center (VA hospital)			[2] 69,407
Erie: Suggested area health education center (VA hospital)			[2] 138,440
Reading: Suggested area health education center			[1] 290,600
Pittsburgh: Suggested area health education center			[1] 2,386,100
Scranton-Wilkes-Barre-Hazleton: Suggested area health education center			[4] 579,000
York: Suggested area health education center			[1] 311,900
Puerto Rico:			
San Juan: University of Puerto Rico	268	584	[2] 225,000
Mayaguez: Suggested area health education center			[2] 83,850
Ponce: Suggested area health education center			[2] 99,000
Rhode Island: Providence: Brown University (2-year school)	20	313	[1] 749,100
South Carolina:			
Charleston: Medical College of South Carolina	326	599	[2] 69,925
Columbia: Suggested area health education center (VA hospital)			[2] 97,433
Greenville: Suggested area health education center			[2] 66,188
South Dakota:			
Vermillion: University of South Dakota (2-year school)	86	132	[2] 6,102
Rapid City: Suggested area health education center			[2] 42,399
Sioux Falls: Suggested area health education center			[2] 65,466
Tennessee:			
Memphis: University of Tennessee	738	1,362	[1] 760,500
Nasbville:			
Meharry Medical College	278	379	[1] 531,000
Vanderbilt University	227	709	[1] 531,000
Chattanooga: Suggested area health education center			[1] 299,000
Knoxville: Suggested area health education center			[illegible]93,500
Texas:			
Dallas: University of Texas Southwestern	411	1,068	[1] 1,404,[illegible]
Galveston: University of Texas Medical Branch	606	945	[2] 67,175
Houston:			
Baylor University	351	857	[1] 1,787,600
University of Texas Medical School (developing fall 1971)			[1] 1,787,600
San Antonio: University of Texas Medical School	105	265	[1] 834,000
Lubbock: Texas Technological University (developing)			[2] 128,691

TABLE 1.—UNIVERSITY HEALTH SCIENCE CENTERS AND CARNEGIE COMMISSION GOALS FOR NEW UNIVERSITY HEALTH SCIENCE CENTERS AND AREA HEALTH EDUCATION CENTERS BY 1980, BY STATE—Con.

State, city, and institution	Enrollment		Population
	M.D. candidates	Total	
Texas—Continued			
Amarillo: Suggested area health education center (VA hospital)			[2] 137,969
Beaumont: Suggested area health education center			[1] 315,500
Corpus Christi: Suggested area health education center			[1] 292,400
El Paso: Suggested area health education center			[1] 348,300
Fort Worth: Suggested area health education center			[1] 657,000
Odessa: Suggested area health education center			[2] 80,338
Utah:			
Salt Lake City: University of Utah	259	661	[2] 189,454
Cedar City: Suggested area health education center			[2] 7,543
Vermont:			
Burlington: University of Vermont	232	462	[2] 35,531
Rutland: Suggested area health education center			[2] 18,305
Virginia:			
Charlottesville: University of Virginia	319	697	[2] 29,427
Richmond: Medical College of Virginia	451	1,037	[1] 508,500
Norfolk-Portsmouth: Recommended new university health science center (VA hospital nearby at Hampton)			[1] 646,400
Roanoke: Suggested area health education center			[2] 97,110
Washington:			
Seattle: University of Washington	334	1,940	[1] 1,261,600
Spokane: Suggested area health education center (VA hospital)			[1] 266,300
Walla Walla: Suggested area health education center			[2] 24,536
Yakima: Suggested area health education center			[2] 43,284
West Virginia:			
Morgantown: West Virginia University	250	667	[2] 22,487
Charleston: Suggested area health education center			[2] 87,796
Parkersburg: Suggested area health education center			[2] 44,797
Wisconsin:			
Madison: University of Wisconsin	403	1,307	[2] 126,706
Milwaukee: Marquette University	412	1,001	[1] 1,342,400
Eau Claire: Suggested area health education center			[2] 37,987
Green Bay: Suggested area health education center			[2] 62,888
Wausau: Suggested area health education center			[2] 31,943
Wyoming:			
Casper: Suggested area health education center			[2] 38,930
Cheyenne: Suggested area health education center (VA hospital)			[2] 43,505
Total enrollment	35,833	89,195	

[1] Estimated population of standard metropolitan statistical areas, 1967, from U.S. Bureau of the Census, Current Population Reports: Population Estimates, ser. P–25, No. 411, Washington, D.C., 1968.

[2] Population of urban place, from U.S. Census of Population, 1960.

[3] Interns, residents, and other postdoctoral students were not reported.

[4] 1967 population of Wilkes-Barre-Hazelton, plus 1960 population of Lackawanna County, of which Scranton is the county seat.

Source: American Medical Association: Medical Education in the United States, 1968–69, Chicago, 1969, pp. 1467 and 1560–1561. Identification of locations of recommended university health science centers and area health education centers is based on analyses by the Carnegie Commission staff. Enrollment data are for 1968–69, and developing medical schools with no enrollment figures had not admitted any students by that time.

A PRELIMINARY PROPOSAL FOR THE DEVELOPMENT OF AREA HEALTH EDUCATION CENTERS USING VETERANS' ADMINISTRATION FACILITIES AS THE CORE OF SUCH A COOPERATIVE ENDEAVOR

(Prepared by Veterans Administration, Department of Medicine and Surgery, Washington, D.C., April 1, 1971)

FOREWORD

The potential of the Veterans Administration Department of Medicine and Surgery for developing Area Health Education Centers in accordance with the suggested recommendations of the *Report of the Carnegie Commission on Higher Education* (pages 55–57) becomes clear when measured against the on-going activities and potential that exist in the Veterans Administration health care system. The fact is that in certain locations Veterans Administration hospitals are either already serving such a function or their activities can become the basis for such a center by the expansion of their current activities and affiliations.

THE RECOMMENDATIONS

The Commission recommends the development of area health education centers in areas at some distance from university health science centers which do not have sufficiently large populations to support university health science centers of their own, and in a few metropolitan areas needing additional training facilities but not full health science centers. These area centers would be affiliated with the nearest appropriate university health science center and would perform somewhat the same functions recommended for university health science centers, except that the education of M.D. and D.D.S. candidates would be restricted to a limited amount of clinical education on a rotational basis, and research programs would be largely restricted to the evaluation of local experiments in health care delivery systems.

The Commission recommends the development of 126 new area health education centers, to be located on the basis of careful regional planning.

(From *A Special Report and Recommended by The Carnegie Commission on Higher Education*, October 1970.)

THE OPPORTUNITY

The Veterans Administration Department of Medicine and Surgery welcomes the opportunity to encourage, support and provide the nucleus for Area Health Education Centers as described in the following section of the Report of the Carnegie Commission on Higher Education:

The role of area health education centers

In some parts of the country the distances between university health science centers are likely to be very great, as in the sparsely populated mountain states. Elsewhere, concentration of people in congested urban areas would overwhelm the facilities of even the largest health science center. In both types of areas there should be "area health education centers," which would provide facilities for patient care, often on a referral basis from surrounding areas; educational programs for house officers and, to some extent, for M.D. candidates who could rotate through an area health education center from a university health science center; clinical experience for allied health students; and continuing education programs for health manpower.

These area health education centers, in essence, would be satellites of the university health science centers and would be visited on a regular basis by the faculty of the health science centers with which they were affiliated. Their educational programs would be developed and supervised by the health science faculty, and their patient care functions would rely on the expertise of the health science center personnel. The area centers in turn would provide assistance and counsel to the community and neighborhood health care facilities, including the private practitioner. . . .

The nucleus of an area health education center would be a hospital, usually a community hospital, but perhaps in some cases a Veterans' Administration hospital. The house officers at the hospital would receive instruction from the faculty of the medical school with which the center was affiliated, in most cases on a visiting basis, but there would be a need for a small group of faculty members permanently located in the center to plan and administer both the educational programs for the house officers and continuing education programs for physicians and other health workers in the surrounding area. M.D. and D.D.S. candidates would receive part of their clinical instruction in such centers on a rotating basis. Within the hospital, or adjacent to it, there would have to be office space for faculty members and other administrators of the educational programs as well as classrooms. Like the university health science centers, the area centers should cooperate with comprehensive colleges and community colleges in the area in planning curricula for allied health workers.

THE POTENTIAL

The potential of Veterans Administration facilities for encouraging, supporting and providing the nucleus of such Area Health Education Centers becomes obvious when their on-going activities and future plans are measured against the functions called for by the Report, as follows:

1. To maintain a community hospital of outstanding quality, many of whose patients would be admitted on a referral basis from smaller communities in the surrounding area

Although a VA hospital cannot be "maintained as a community hospital", as such, it can cooperate with existing community hospitals in providing care to patients within the area they serve together. Over and above referring veteran patients between the regionalized VA hospitals in the area, the VA hospitals may actually admit non-veteran patients for highly specialized services not otherwise available in the community and, conversely, may also refer its patients to the community hospitals on a fee-for-service or contract basis for services it may not have, in accordance with the Sharing Law (P.L. 89–785). Effective patient and family counselling can increase the use of VA facilities and benefits in the management of catastrophic illness, and long term chronic disease and debility.

2. To conduct educational programs under the supervision of the faculty of the university health science center with which the area center is affiliated

With an education and training budget of just under $100 million per year, the VA hospitals and clinics cooperate with virtually all of the nation's medical and dental schools, and well over 500 universities, colleges, junior colleges and technical institutions, to provide at least some part of the education and training of about 50,000 health services personnel. The experience and demonstrated ability of the VA to develop, foster and conduct these programs has by no means been limited to those VA hospitals which are direct affiliates of Medical Schools. Frequently, the VA hospitals geographically distant from medical centers are secondarily or indirectly affiliated with the centers for purposes of residencies and continuing education for professional and allied health personnel including pharmacy, social work, psychology, etc.

Opportunities for flexible staff assignments to enhance this capacity is virtually unique to a system the size of the VA that includes 68,000 full time employees who provide direct patient services representing 5,100 physicians, 770 dentists, and 28,000 nurses and other professional allied health personnel in some 25 fields qualified at the baccalaureate level and above.

3. To have these educational programs include

a. Residency programs

Some 12 VA hospitals not now directly affiliated with medical centers provide American Board-creditable residencies in the manner prescribed by the Commission. Other services in these hospitals could, with relatively minor investment for personnel and facilities, be similarly qualified in at least 10 other VA hospitals which offer opportunities for such programs.

b. Clinical instruction for M.D. candidates and D.D.S. candidates who would come there from the university health science center on a rotating basis

Students enrolled in 72 medical and 10 dental schools receive some of their clinical instruction in VA hospitals. Several of these schools have embarked on programs to decentralize and expand their M.D. and D.D.S. programs and are planning to use certain non-affiliated VA hospitals for clinical instruction for their students. Modest investments, principally in shared support of teaching staff, would serve to bring these arrangements to fruition.

c. Clinical experience for students in allied health programs

During the past year a total of 40,000 allied health students, representing some 20 to 25 fields of instruction, will receive all or part of their supervised clinical experience in VA hospitals. More than 7,000 others received complete on-the-job training for employment as nursing assistants and service aides. Virtually every one of the 166 hospitals participate to some degree in this type of effort, and affiliate with at least two or three community vocational schools or junior colleges in the training of nurses at the LPN or RN levels. An example of the systems responsiveness is the fact that 12 VA hospitals during the current year will have formed affiliations in nationally recognized programs for the training of Physician Assistants while planning others for the coming year. Of these 12, seven are not part of university health science centers but have been chosen specifically to provide the clinical experience in a setting more nearly like that in which Physician Assistants are most likely to work.

d. Continuing education programs for health manpower in the area, conducted in cooperation with local professional associations

The Department of Medicine and Surgery makes available a total of approximately $4 million annually for the in-service training, continuing education and career development of its own employees. Much of this training is arranged for and conducted within the system itself; however, it is either available or could easily be made available to non-VA personnel. The Sharing Law (P.L. 89–785) also created the Exchange of Medical Information Program to strengthen the qualifications of the staff of VA hospitals not affiliated with medical schools and/or located remote from medical teaching centers. Its purpose is "to foster . . . the widest possible cooperation and consultation among all members of the medical profession . . ." whether within or outside the VA, are designed to promote ". . . an environment of academic medicine . . . attract and retain highly trained and qualified members of the medical profession . . ." in distant and medically remote communities and *provides the legislative authority for making available the relatively few "coordinating dollars" required to effect such programs.* Utilizing such resources, for example, six VA hospitals in the widely scattered Rocky Mountain areas have coordinated their programs for continuing health education of hospital personnel and encouraged them to become education resources for the hospitals and health professionals of the surrounding communities; the National Medical Audiovisual Center in Atlanta, Georgia has made a study of the professional staffs of several isolated VA hospitals and is designing, conducting and evaluating a comprehensive program to provide audiovisual materials and equipment for continuing education tailored to special identified needs of those staffs; and in Nebraska, three hospitals have established a closed circuit television linkage with the Nebraska Psychiatric Institute which remits combined teaching rounds, lectures and instantaneous professional consultations, including interpretation of such things as EEG and results of laboratory tests.

4. To provide guidance to comprehensive colleges and community colleges in the area in the development of training programs for allied health professions

All of the current proposals for establishment, reorganizations or realignment of the methods for the delivery of health care such as Health Care Corporations and Health Maintenance Organizations agree that the responsibility for the production of health manpower must be shared by the nation's educational and health institutions. No other system or organization of health care institutions has had the collective experience in dealing with the educational system at all levels as the VA system. It has been widely agreed that the major deterrent to broader expansion of health related curricula in colleges, universities and particularly in community colleges is the lack of experienced staff for planning and conducting the pre-clinical didactic courses required for these programs. Space, equipment, and laboratories become unexpectedly expensive for new and rapidly expanding community and private colleges. Employment opportunities in the VA in the late 1940's and early 1950's, and the career advantages of continued Civil Service employment have resulted in the presence within the VA system of a large number of highly qualified senior level professional personnel who are experienced on-the-job teachers. Such professionals could benefit mutually with educational institutions by appointment to teaching and administrative positions in colleges and universities on a full or part-time basis. This unparalleled reservoir of expertise includes 15,500 professional nurses, (3800 baccalaureates, 650 masters and 5 doctorates), 3,775 clinical laboratory personnel (850 clinical scientists and 1,200 certified medical technologists), 1,775 social workers, 750 clinical psychologists, and nearly 3,000 representatives of the various rehabilitation therapies, including physical therapists, occupational therapists, blind rehabilitation therapists, alcohol and drug addiction counselors, speech pathologsts, etc.

The VA hospital library service has been a leader in standardizing and automating the availability of medical literature. Its system of service is now an integral part of the regional planning of the National Library of Medicine and in many VA hospitals, the library service could be readily expanded to make this national resource accessible to the entire community. Many VA hospitals, particularly those outside areas of high population density, also have extensive buildings and facilities that could easily be renovated or grounds that accommodate inexpensive pre-fabricated construction suitable for classrooms, laboratories, libraries, and meeting facilities.

5. To cooperate with hospitals and community agencies in the planning and development of more effective health care delivery systems

One basis for VA-community cooperation is the mechanism established for the part-time and consultant appointments of community practitioners of medicine and dentistry to VA services. This system has served as a traditional and recognized mutually advantageous resource of young and aggressive staff for the VA hospitals, and an income supplement for practitioners as they establish themselves in a community. As a focus for planning and development of changes in health care delivery systems, the VA hospital also is looked upon as a trusted, functioning, reasonably successful, and a non-threatening adjunct to the health care resources of a community and not a super-imposed Federal effort.

6. To conduct limited research programs concerned primarily with the evaluation of health care delivery systems

Within its clearly defined mission of providing the best possible care to veterans, the Department of Medicine and Surgery has continued to face the necessity of experimenting with new systems to ensure that such care includes new knowledge, new techniques and meets ever-changing demands of new age groups of beneficiaries of variations in the nation's socio-economic environment. For example, in recent months the VA system has continued to meet the demands of a ten-fold increase in admissions for drug and alcohol addiction; adjusted its services to provide care for a marked increase in the incidence of chronic pulmonary disease among World War II veterans reaching their 60's; and established the nation's most extensive integrated system of dialysis services and kidney transplantation. In addition, a program of hospital based home health care has been established to follow the chronically ill patient into the home, and plans are underway for offering ambulatory care in lieu of hospitalization. These changes in service are responses to the requirements for new health delivery systems based on an accumulation of information that can only be obtained in a semi-closed health care system of the size and scope of the VA. These responses represent the application of management engineering, computer techniques and planning and budgeting experience by the Department of Medicine and Surgery which could serve as an invaluable basic resource for broader community planning and research.

NOTE: In addition to the foregoing activities reflecting multifaceted relations of VA hospitals with the community hospitals, medical societies, voluntary health organizations and local Regional Medical Programs, the Veterans Administration's Department of Medicine and Surgery also maintains a close working relationship with the American Medical Association, American Hospital Association, Association of American Medical Colleges and virtually all other national organizations which represent the medical specialities and the allied health professions. It also works closely with other Federal Agencies such as the Department of Health, Education and Welfare and its various services concerned with the development of improved health care services and the encouragement of increased and better qualified manpower.

THE LOCATIONS

A preliminary study made by the Veterans Administration Department of Medicine and Surgery indicates that the following criteria for the location of the Area Health Education Centers, as suggested by the Report, are consistent with those that exist in selected Veterans Administration hospitals, despite the limitations mentioned:

The location of area health education centers

In developing its suggestions for the location of area health education centers, the Commission has carefully considered the following criteria: (1) distance from an existing university health science center, a developing center, or a recommended new health science center; (2) the population of the community and its surrounding area; and (3) the objective of providing for enough area centers so that no portion of a state or region would be remote from such a center. Nevertheless, in sparsely populated states the centers would inevitably have to be farther apart than in more thickly populated states.

The Commission believes that the final selection of locations for area health education centers should be based on careful regional planning. We are therefore *suggesting* the locations indicated by our analysis but are not firmly *recommend-*

ing them. However, we believe that the number of centers indicated by our analysis is probably quite close to the number that would be needed to provide adequate geographic distribtuion of such centers.

In addition to the criterion of geographic distribution, we have also applied a criterion of at least one university health science center or area health education center for every 1,500,000 persons in the large metropolitan areas. On this basis, we are recommending the development of five area health education centers in the Los Angeles metropolitan area, one in the San Francisco-Oakland metropolitan area (in the East Bay), two in Detroit, one in Pittsburgh, and one in the New York metropolitan area.

The Commission is suggesting, in all, 126 locations for new area health education centers, indicated on Map 2 and listed in Appendix B, Table 1. The appendix table indicates where there is a Veterans' Administration (V.A.) hospital that is not affiliated with a medical school in a community for which an area health education center is suggested. However, the Commission does not believe V.A. hospitals would be appropriate as nuclei for area health education centers unless their policies were changed to permit the admission of patients of all types instead of veterans only. Under present policies, their patients are almost exclusively male and tend to be older persons suffering from long-term disabilities.

As the population grows and the centers develop, there may well be a case for converting some of these proposed area health education centers into university health science centers in the future.

We estimate that, if our recommendations for new university health science centers and suggestions for area health education centers are carried out, by 1980 about 95 percent of the population will be within no more than an hour's traveling time from a university health science center or an area health education center.

The following letter was sent to eight Veterans Administration Hospitals selected as having unusual potential as locations of area health education centers: The eight hospitals are: VA Center, Boise, Idaho; VA Center, Togus, Maine; VA Hospital, Erie, Pennsylvania; VA Hospital, Fresno, California; VA Hospital, Lincoln, Nebraska; VA Hospital, Oteen, North Carolina; VA Hospital, Saginaw, Michigan; VA Hospital, Tuskegee, Alabama.

Veterans' Administration,
Department of Medicine and Surgery,
Washington, D.C., September 14, 1971.

Dear Hospital Director: The joint Administration-Department of Health, Education and Welfare Steering Committee for the development of Area Health Education Centers initially related to VA Hospitals has met and and considered the results of the recent site visits. As discussed during those meetings, such as center will essentially follow the concept introduced in the October 1970 report of the Carnegie Commission on Higher Education, and called for in the President's Health Message of February 18, 1971. As such, it will bring together the various health service and education facilities and resources in medically underserved areas. This is to be accomplished by planning and implementing a program of developing additional health manpower to meet the identified health needs of the area, while improving the mechanisms by which health care is delivered.

This is to inform you that your hospital and community are considered eligible for assistance in further development of this concept. Accordingly, you are authorized to provide to this office a proposed budget requirement to permit you to proceed to the point where a formal proposal for implementation may be submitted and evaluated.

It is the opinion of the Steering Committee that further planning at the local level is necessary prior to implementation of a sufficiently coordinated and cohesive program to adequately embody the basic principles upon which any AHEC must be structured. Recognizing the necessity for a major commitment of staff and time to proceed with such planning, we are prepared to support your office with planning funds. This may include the position of a coordinator, a secretary, and sufficient consulting and travel funds to permit the development of the necessary resources from which an operational proposal can be developed.

To assist you and your planning committee in your efforts, should you elect to proceed, the following basic principles are provided for your consideration:

1. The program of the AHEC should clearly demonstrate the ability of institutions in your area to work together in meeting a mutually defined goal with some measure of commitment on the part of the partners to include a contribution to the total effort. This contribution may be in money or kind.

2. There should be an agreed-upon geographical area to be served by the AHEC, and the institutions forming the consortium must indicate their willingness to accept the responsibility of meeting the needs of this area as part of their responsibility.

3. There should be defined goals or target objectives to which the AHEC addresses itself. These should be sufficiently well described to permit periodic evaluation of accomplishment.

4. There should be available a sufficiently accurate and functional data base which indicates the necessity for the establishment of such goals or objectives. These data may be in terms of availability and distribution of health care personnel or related unmet health needs.

5. There must be a recognized capability of the consortium to meet the objectives, planned redirection of current efforts, new activities, or expansion of those already in operation, if support is provided. This capability should be in terms of either educational programs and/or clinical capacity.

If you and the other members of your health community wish to proceed, a planning and coordinating committee representing the key organizations who will participate in development of a formal proposal should be formed. Their names and titles, and those of the organizations they represent, must be submitted to this office prior to, or at the time of, your request for planning funds. Beyond the financial support already mentioned, the VA and representative offices of DHEW are prepared to assist this group in further development of its plans. In addition to a set of broad guidelines now being prepared, knowledgeable staff from the VA's Department of Medicine and Surgery and from the Washington staffs of the National Institute of Health's Bureau of Health Manpower and the Health Services and Mental Health Administration, and their representatives in the Regional Offices responsible for your location, will be provided on request to meet with your planning group.

Operational program proposals submitted after the planning effort, although made to a single location, should identify Federal funding sources and will be coordinated among the appropriate agencies in Washington. The specific details concerning this format will be provided in the aforementioned guidelines.

It should be clearly understood that the VA is providing immediate support for the necessary coordinated planning through your office, including the necessary space, personnel support and consulting funds, and it is doing so in fulfillment of the VA objectives of improving veteran patient care. Operational funds which may be forthcoming will similarly represent the authorities and mission of each of the agencies involved, and VA funds which may be subsequently provided will also require that they be utilized only in meeting the objectives of the VA.

If, after consulting the other members of your community, you wish to proceed within the broad principles as stated above, you may request of this office funds in support of further planning activity.

Sincerely,

JOHN D. CHASE, *M.D.*,
Associate Deputy Chief Medical Director.

Senator Cranston. Dr. Musser, in your prepared statement you refer to the approach in my bill regarding providing care for dependents of 100-percent, service-connected veterans and the dependent survivors of veterans who died with service-connected conditions, as "adding potentially 40 million adults and children to the patient care liability of the VA hospital system."

Can you explain that 40 million estimate? And that use of the words "patient care liability" sounds to me sort of characteristic of the OMB's compassion on the subject.

Dr. Musser. When I read this statement, I read "in adding a substantial number of" instead of "potentially 40 million."

Senator Cranston. I am delighted that that change was made. I did not note it.

Dr. Musser. And you commented, this document was late in arriving and we would like to check the 40 million a little further before it stands in the record.

Senator Cranston. Good.

One of the categories of dependents which I feel has a particularly difficult position in terms of access to health care is the dependents of totally disabled service-connected veterans. They are unable, for the most part, due to the inability of the veteran to enter the employment market, to pay for their own care or to join health insurance programs, because of the preexisting disability of the veteran.

Don't you believe we have a moral obligation to the veteran to provide necessary medical care to members of his family who, by virtue of the veteran's service-connected, 100-percent disability, cannot afford private health coverage?

Dr. Musser. Certainly, if there were no other mechanism by which care could be provided to them, I would be concerned about it. On the other hand, in the relatively few years I have been associated with the Veterans' Administration, the matter of the care of this particular category of dependents has not come into the foreground until just the last couple of years. It apparently has not been too serious a problem.

Senator Cranston. In regard to this particular category, it seems to me that if the disability came from service for the country; namely, the Government representing the country, the Government has a responsibility to see that they are not left without medical care.

Dr. Musser. That is an important policy issue. I think someone besides me is going to have to decide that.

Senator Cranston. Do you feel that home health care should be an important part of any modern medical care program in this day and age?

Dr. Musser. Yes, I do. We have already initiated that.

Senator Cranston. Could you please describe the extent to which the VA is involved in providing health care at the homes of veterans?

Dr. Musser. We are doing this presently on a pilot basis.

Dr. Wells. Our experiments so far have extended to only six hospitals, where home health care is being extended. Actually we have a modification of home health care that goes on at psychiatric hospitals in which our psychiatric social workers get together with certain other paraprofessionals to visit in the homes.

So we have quite a little experience in the home health care pattern. It has payoffs in all areas, but I would say particularly in the psychiatric area, where the division of the family is illogical. When one treats a psychiatric patient, he almost necessarily must treat the family in its own total environment.

Senator Cranston. Isn't it important to do all we can to provide the maximum home care possible, for financial savings purposes, as well as for other medical reasons?

Dr. Musser. We have a move in that direction; yes, sir.

Senator Cranston. Dr. Musser, do you believe that there are certain restrictions with respect to the ability of a VA psychiatrist to provide effective treatment to a disturbed veteran when the treatment of that veteran also requires the treatment of his family?

Dr. Musser. Yes. We are aware of that restriction.

Senator Cranston. Do you feel we should seek to remedy it?

Dr. Musser. We are presently exploring that within the system now. We want to make sure that our current regulations would not provide for some measure of this, and if indeed we find that this cannot be done, then I think we might have to begin to consider legislation. We have been able to identify certain types of care that are considered to be adjunctive to the primary problem of the patient. We have begun to wonder whether the involvement of the wife and family in the psychiatric situation could not be considered adjunctive to the proper resolution of the veteran's problems.

To illustrate, Mr. Corcoran will comment.

Mr. Corcoran. Mr. Chairman, I don't think we have been given the question yet. We would be happy to take a look at it.

Senator Cranston. Is that the way we consider the dependent, adjunctive to the care of the veteran? As I understand it, there are occasions when a conscientious psychiatrist, who feels it is necessary, proceeds to give assistance to the family even though the situation is not clear. And it would seem to me to be advisable to make the situation clear and relieve the individual psychiatrist of that burden and that liability.

Dr. Musser. This seems particularly true in the face of many of the changes that have taken place in psychiatric care, particularly as more veterans are being cared for on an ambulatory basis. They live at home where so many of them did not before.

Senator Cranston. Could you bring us up to date on the status of followup efforts which have been made by the VA, since the San Fernando Valley, Calif., earthquake and Fayetteville, N.C. tornado. Does not part of S. 2354, as it relates to earthquakes and other disasters, merely set forth the procedure which in most respects you are already following in light of these two recent tragedies?

Dr. Musser. I would like to ask Mr. Miller to answer that question. He is the assistant administrator for construction.

Mr. Miller. Mr. Chairman, since the San Fernando earthquake, we have taken a number of steps.

We have established an Earthquake and Wind Forces Committee. Membership is comprised of an outstanding seismologist and structural engineers. We have Dr. Bruce A. Bolt from the University of California, Dr. Mete Sozen from the University of Illinois, and Mr. Roy G. Johnston of Brandow Johnston Associates in Los Angeles who is the structural engineer. Also, on this committee, is the Director of Civil Engineering in the Veterans' Administration, Mr. James Lefter.

This committee has two objectives. One is to review the building codes that are now current throughout the Nation as they relate to earthquakes and wind forces with the goal of establishing a standard within the Veterans' Administration that will adequately protect our buildings against such forces.

No. 2, the committee is also establishing techniques and procedures for evaluating our older buildings that were built before seismic codes were in effect. In addition, we have begun evaluation of those buildings that we consider most critical in southern California, to ascertain the safety of those buildings and identify work that may be needed to make them acceptable for earthquake risks.

In addition, we are now working on evaluation of buildings in the Pacific Northwest, going as far as Salt Lake City, Utah. We have 11 stations that have buildings that were built without seismic protection as such that we are evaluating now.

I might say, as you perhaps know, Mr. Chairman, that the Veterans' Administration has traditionally complied with building codes; national, State, and local codes. As you know, in the case of San Fernando, we had buildings there that were constructed prior to the Uniform Building Code, and those buildings were severely damaged. Only the buildings that were built in the early 1940's and were built in compliance with the then Uniform Code withstood the earthquake well.

Senator CRANSTON. One problem was whether the building codes are adequate. I would like to urge that the most expeditious steps be taken to clear up the situation as far as the VA is concerned.

Has the VA received many claims from patients or survivors of patients involved in the San Fernando earthquake?

Mr. CORCORAN. Mr. Chairman, I am not sure of the answer.

Senator CRANSTON. Could you provide the details for the record?

Mr. CORCORAN. My associate, Mr. Robert Coy, might have information.

Mr. COY. There have been some claims involving the loss of personal property. There have not been any major claims involving personal injury or loss of life.

Senator CRANSTON. I have been considering the possibility of introducing legislation to provide limited relief to these victims of the San Fernando hospital collapse.

I believe there is a precedent for such relief bills for disasters at VA hospitals. Is that not correct?

Mr. CORCORAN. There is some precedent, Mr. Chairman, in which the Federal Government, absent any legal responsibility, has undertaken special private legislation to adopt a kind of compassionate responsibility. There is precedent to that extent.

Senator CRANSTON. Assuming a reasonable limitation on recoveries, such as $25,000, can you give me your views on the advisability of such legislation to provide reimbursement for the damage to life and property caused by that hospital collapse?

Mr. CORCORAN. I cannot give you a direct response at this time. I would like to defer. We understand there is a study being conducted, in which the Office of Management and Budget is participating, in an effort to determine on a government-wide basis, again where there is no legal responsibility, what ought to be the Federal Government's undertaking in those cases. When the study is conducted, it would help us answer your questions.

Senator CRANSTON. If you could add anything to the record on this point, I would appreciate it.

What was the Government's position on the prior precedent? Did they oppose it?

Mr. CORCORAN. I'm not sure.

Senator CRANSTON. Would you submit that for the record?

(Subsequently, the Veterans' Administration furnished the following material:)

> Legislation has been enacted in past years authorizing payments by the Federal Government for losses sustained in disasters, notwithstanding the absence of legal responsibility therefor. These include Public Law 378, 84th Congress and Public Law 86–381 (providing relief for losses sustained in the April 1947 disaster at Texas City, Texas); Private Law 89–363 (providing a compensatory payment to the estates of 18 members of the U.S. Navy Band who died in a plane crash during a flight from Buenos Aires, Argentina, to Rio de Janeiro, Brazil, on February 25, 1960); and Public Law 89–757 (providing relief for deaths and personal injuries resulting from a U.S. ordnance plane explosion in Bowie County, Texas, in July 1963).
>
> The following is furnished in response to your inquiry as to the Government's position on these precedents. As regards Public Law 378, 84th Congress, the Departments of the Army and Justice opposed the enactment of the bill (S. 1077, 84th Cong.) as introduced. The Department of Justice advised, however, that if certain suggested amendments were adopted, they would interpose no objection. The Committee (in S. Rept. No. 684, 84th Cong.) noted that these amendments had been adopted. With respect to a predecessor bill of H.R. 4821, 86th Congress (which was enacted as Public Law 86–381), the Department of the Army advised:
>
> "In view of the compassionate basis upon which the Congress enacted relief legislation for the victims of the Texas City disaster, this Department considers the exercise thereof a prerogative of the Congress and does not deem its views thereon material to the merits of the legislation."
>
> The then Bureau of the Budget, however, objected to the bill's enactment on both general and specific grounds.
>
> In a letter of May 19, 1965, on H.R. 5912, 89th Congress (ultimately enacted as Private Law 89–363), the Department of the Navy advised that it could not—
>
> "* * * support the enactment of H.R. 5912 because to provide by legislation, additional financial remuneration for the next of kin of the eighteen band members who died in the air collision over Rio de Janeiro, would be singling out these limited few for preferential treatment, discriminate not only against the next of kin of the seventeen other Navy men who died in the same crash, but also against the many other dependents and families who have, under comparable circumstances, lost their husbands or sons or daughters in the service of their country. * * *"
>
> Our agency records do not indicate the Executive branch position taken on the bill which was enacted as Public Law 89–757.

Senator CRANSTON. I would like to express some particular concern I have about the operation of the VA medical program in California, I wonder if you can tell me when the evaluation of the ombudsman program at Los Angeles Extended Care Hospital will be completed and when a final decision on the future of that program, which was discontinued as of June 30, 1971, will be made.

Dr. MUSSER. I would expect the evaluation to become available very shortly.

Senator CRANSTON. Let us know the moment it is.

Dr. MUSSER. I will.

Senator CRANSTON. In recent trips to California that I have taken and my staff has taken, we have received disturbing information about the status of the plan to revitalize the VA neuropsychiatric hospital in conjunction with the new affiliation with the neuropsychiatric institute at UCLA.

Specifically, it seems to me, whatever the reasons may be, the VA has given the appearance of not responding to the clear commitments which were made to UCLA and to individuals who were recruited for positions at Brentwood and UCLA with the expectation that the new program there would have substantial research support both in terms of available funds to support projects and funds for providing new research space.

As a result of this demoralization, one young psychiatrist recruited for Brentwood resigned within a week when he saw these commitments were not about to be met. I think this is an enormous tragedy.

You will recall my predecessor Subcommittee on Veterans' Affairs took extensive testimony about conditions in Brentwood in late 1969 and early 1970 in hearings, both in Washington and in Los Angeles. I tried to do all I could to encourage UCLA to establish a new affiliation with Brentwood, and, wherever I could be helpful, to try to assist in convincing highly qualified physicians to come to Brentwood. It seems to me, those of you at the top of the department of medicine and surgery are totally sympathetic and sincere in your commitment, but when it comes time for research funds to start flowing, those down beneath you do not have a clear idea of what commitments were made, and where you really stand in that matter.

I would appreciate personal attention by you, Dr. Musser and Dr. Wells, in resolving and expediting funds for Brentwood consistent with the commitments that were made so that all the progress that has been made in the last 18 months is not vitiated.

Dr. **Musser**. This has had our personal attention. The matter of the availability of research funds has been clarified with Dr. West and with Dr. Philip May. One of the unfortunate circumstances there is, Dr. May, who does not fully understand the system, was unaware of the fact that even though we were told that the money was available, he needed to tell us when he wanted it. And when he did that, he got it.

Now, there is a problem in terms of laboratory space, because we have not been able to move into the modernization of buildings at Brentwood as rapidly as we might. We have talked with Dr. West and Dr. May about that, and are now trying to improvise adequate laboratory space for the new staff. I think that we are more on top of that situation now than we have been for some time.

Senator **Cranston**. I'm glad to hear that. Now that the Congress has voted $4 million in extra research funds, I hope a reasonable part of this funding will be to support research at Brentwood. And I hope some of that funding will go to the biomechanical prosthetic laboratory at the University of California at Berkeley now receiving $160,000 annually, about which I spoke to you at the end of our last hearing.

Dr. **Musser**. We are looking into that.

Senator **Cranston**. I keep receiving rumors from many places, indicating that the construction of a new hospital at Loma Linda, Calif., and replacement of the hospital complex in West Los Angeles is about to be announced. Can Mr. Miller enlighten me on this?

Dr. **Musser**. We hear the same rumors you do, Mr. Chairman.

Mr. **Miller**. I have nothing to add.

Dr. **Musser**. He has heard the same rumors.

Senator **Cranston**. At a minimum, I would appreciate receiving from you advance notification of any such conflicting announcement, either directly to myself or through Mr. Steinberg.

I have received disturbing reports regarding cutbacks in the VA open heart surgery program. I believe this refers to a June 1, 1971, letter to all VA hospital directors from you Dr. Musser. I am particularly concerned about the impact of this cutback on the outstanding surgical team at Palo Alto Hospital and Stanford University.

According to advice I received, the Palo Alto team has been cut back from eight operations to two operations a week on the basis that the "bypass procedure for coronary heart disease" is now considered experimental in nature by VA. Isn't it true, in many instances, this procedure is the only alternative to prolong life and it is not being curtailed in many other open-heart programs in the country?

Dr. **Wells**. There have been a lot of differences of opinion among the cardiac surgeons about this procedure. The Veterans' Administration has been in the business of doing surgical procedures for coronary disease for more than 10 years. We have gone through quite a number of different procedures that in the past have proved to be less than successful. Many of our advisers at the present time, speculate that this new procedure, the bypass, will be no more successful than its predecessors.

This is strictly a matter of opinion. Nevertheless, we are doing these procedures in several cooperative study hospitals. The largest load in this is at the Palo Alto Hospital where they have a very excellent team doing these procedures. They have referrals from a very wide area of the country, all the way from Maine to the entire west coast. This has produced a heavy load of surgical work at Palo Alto Hospital.

The difficulty has not been one of funding that work, but has been multiple problems of actually getting the work through the operating suite and through the team. For one thing, the medical school and the other departments have raised some complaints about overbalancing the program in favor of thoracic surgery. Because of this, they have had great difficulty getting sufficient numbers of qualified anesthesiologists to support the program.

We have recently issued in excess of $100,000, just to carry on this work at that facility. We are also making an attempt to decentralize this program somewhat so that the veteran patient load will not be so overpowering on the Palo Alto Hospital. We are trying to get more of these done at Seattle or some of the other hospitals in order to spread this load. But the academic community out there raised some concern when we were doing up to five and eight a week, Mr. Chairman. You realize of course our first responsibility is to veteran patients who need these services.

Senator **Cranston**. Have any patients been turned away from the Palo Alto Open-Heart Center as a result of the June 1 letter?

Dr. **Wells**. Strictly speaking, I believe, not really turned away. I have talked with the hospital director, Dr. Gottlieb, on this matter on several occasions. A number of patients have been given a separate priority and have been asked to report back at a particular time, 2 or 4 weeks after the period of initial examination. The delays have been due in part to the inconclusiveness of the examination and the desire on the part of the team to see this patient again before the procedure is undertaken.

I followed individual cases in this connection, and I have yet to find one that was literally turned away for lack of funds, although that phrase was used in several instances.

Senator **Cranston**. How many patients are having their operations delayed, at what risk to their lives and futures?

Dr. **Wells**. It would be difficult to say it was at any direct risk in the judgment of the cardiac team out there. These delays have been in patients, as I understand it, where the operation was considered elective from the standpoint of the timing. There were, at one point, 26 patients who were given priority numbers and delayed for a period of time, but that has been misconstrued. The information has not been accurate. It has not been strictly lack of funds. It has been a lack of total resources at that one institution which has been overburdened with this procedure.

Senator **Cranston**. Would not additional funds be needed to restore the level of activity to approximately six to eight operations a week?

Dr. **Wells**. The level of funding that we issued there a couple of weeks ago is at least sufficient to keep them at three or more procedures a week. And we believe that is about all that their supporting personnel can carry safely.

Senator **Cranston**. Stanford's view, expressed to us, is they could sustain six a week if there were funding.

Dr. **Musser**. May I comment, and then Dr. Wells might pick it up, that we find that there is a bit of disagreement locally out there on that figure among the surgeons, the anesthesiologists, nurses, and the supporting personnel upon whom the surgeons must depend. This is part of that problem. The surgeons would like to do six or eight, but the supporting personnel cannot carry this load. Since the supporting personnel cannot safely handle that large a load, then I think it properly must be controlled. The issue is not money.

Senator **Cranston**. Would you give a full description of the situation and of the program for the record.

Dr. **Musser**. It might interest you to know that we do on an average about 60 of these bypass procedures in our hospitals per month.

Dr. **Wells**. We will give you a summary of our experience with this program as of June 1, 1971.

(Subsequently, the Veterans' Administration furnished the following information:)

The following table provides a summary of the VA's experience as of June 1, 1971 with Cardiac Surgery. The percentage figures given are the Operative Mortalities for Cardiac Surgery at ten centers during FY 71 or for the most recent 1–5 years combined period.

CARDIAC SURGERY CENTERS

Hospital	Valve replacement		Coronary bypass		Other		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Houston	19	15	63	11	15	13	97	13
Los Angeles	51	10	19	10			70	10
Oteen	38	10	39	20	3	33	80	20
Hines (Neville 66–70)	152	30	34	14			186	22
Portland	60	13	48	7			108	10
Ann Arbor	7	0	4	25	3	0	14	7
Oklahoma City	5	20	18	11			23	15
Durham	15	7	28	14			43	11
Denver (11 months)	25	8	28	7			53	8
West Roxbury	38	13	8	25			46	15
Palo Alto	64	12	57	2	14	0	138	7
Total	474	13	346	13			855	13
19 VA hospitals surveyed			326	10				
Cooperative study only			185	20				

The total number of operations considered are given in parenthesis. Patients selected for operation in the VA are generally among the higher risk groups of candidates for cardiac surgery.

The two major operative groups (values and coronary by-pass) contain many cases of combined operations (i.e., more than one valve replacement, coronary by-pass plus valve replacement, aneurysmectomy, etc.)

Cardiac surgical activities have a highly significant impact on hospital operations, since they require a relatively great amount of support from other hospital services, such as post-operative intensive care, increased demands for operating room time; greatly increased laboratory testing and X-ray examinations, as well as additional anesthesiologist services. These factors can have a major impact on availability of facilities for the various other hospital services and training programs. Careful and continual planning is essential in order to maintain the overall balance of hospital programs as cardiac surgical services are expanded to meet the demands and needs of veteran beneficiaries for such services.

NOTE: Under certain circumstances a limited number of nonveteran patients may be admitted to VA facilities for these services so long as such treatment does not interfere with or delay the primary mission of the VA to provide care and treatment to veteran beneficiaries.

Senator CRANSTON. There is the buzzer for a vote. This is one roll call that came at an opportune time.

We will take a brief recess and then proceed with the next witness.

I thank you for being with us this morning and for your helpfulness.

We will stand in recess briefly.

(Whereupon, a brief recess was taken.)

Senator CRANSTON. The hearing will reconvene.

The next witness is Dr. Philip R. Lee. Dr. Lee, will you please proceed?

STATEMENT OF DR. PHILIP R. LEE, CHANCELLOR OF UNIVERSITY OF CALIFORNIA, SCHOOL OF MEDICINE, SAN FRANCISCO, CALIF.

Dr. LEE. I am pleased to have the opportunity to testify on behalf of the University of California on a series of bills related to improving the ability of the Veterans' Administration to provide high quality health services for veterans and enlarging the authority of the Veterans' Administration to permit it to assist effectively in meeting the Nation's health manpower crisis. The changes proposed in the Veterans Health Care Reform Act of 1971 (S. 2354); the Veterans' Administration Continuing Medical Education Act (S. 2355); and the Veterans' Administration Health Manpower Training Act (S. 2219) will contribute significantly to the achievement of these objectives.

Although some details may require modification, I want to strongly support S. 2354, S. 2355, and S. 2219. These proposals provide needed legislative authority and policy direction that are, in my opinion, urgently needed if we are to provide the veterans of the country with the high quality health care that it is their right to expect.

One might ask, why should the University of California as an educational institution be concerned with new legislative authorities relating to the Veterans' Administration?

We are concerned, Mr. Chairman, because the university includes five medical schools, two dental schools, two nursing schools, two schools of public health, as well as schools of pharmacy, optometry, and veterinarian medicine. We have close working relations with the Veterans' Administration, and they have improved the health care for the veterans and have improved the scope and quality of our education and research programs.

My major concern, Mr. Chairman, is that funds will not be requested or appropriated to carry out the essential provisions of these proposals. Members of this subcommittee have worked tirelessly and effectively to increase the appropriations for the VA hospital and medical care programs this year and last year. The results, in terms of the fiscal year 1971 budget, were not entirely satisfactory. This year, a great deal of progress has been made. This is illustrated by the fact that the fiscal year 1972 appropriations bill now contains $204.1 million more than was in the President's budget. These funds are absolutely essential if the VA is to maintain and improve the quality and scope of health care it provides veterans.

In examining the major proposals (S. 2354, 2355, and 2219) before you, I believe there is one basic question that must be answered: What will this legislation do to enhance the quality of medical and other health services for veterans?

A series of related questions must also be answered:

What will the proposals do to make the best use of VA resources in dealing with the Nation's twin crises in health manpower and health care?

What will the proposals do to stimulate innovation and improvements in education and patient care?

What assurance is there of cooperative efforts among the various Federal agencies concerned with health manpower, health facilities and health care, particularly the Veterans' Administration and the Department of Health, Education, and Welfare?

In this subcommittee's hearings in April, Mr. Chairman, you dealt in great detail with the problems of the quality of medical and hospital care in VA hospitals and clinics. You also considered testimony relating to the potential of the Veterans' Administration, in cooperation with the Nation's educational and health care institutions, to help us meet our growing health manpower and health care crises. I will not dwell on the details of those informative hearings, except to note that a number of serious deficiencies were identified. Some of these required adequate appropriations to correct. For others, new legislative authority was clearly required. I believe the proposals included in the bills before this committee correct the major deficiencies in legislative authority that were identified.

Let me turn now to comment on the specific proposals.

S. 2219: VETERANS' ADMINISTRATION HEALTH MANPOWER TRAINING ACT

This is an excellent bill, and I wish to strongly endorse the three major authorities provided:

(1) Provision for expansion of existing Veterans' Administration hospital education and training capacity;

(2) Authority to conduct a pilot program to aid in the establishment of 10 new public, nonprofit institutions which may be medical, health professional, or allied health schools or area health education centers operated in conjunction with the Veterans' Administration facilities; and

(3) Authority to award grants to medical and other health professions and allied health schools which are affiliated with VA medical facilities for programs to expand and increase their capacity to train health manpower.

We believe that S. 2219 is a definite improvement over Senate Joint Resolution 748. The House-passed resolution, however, is an important step forward, and I am certain that whatever differences ultimately exist can be resolved.

Although these proposals differ in detail, they all share a similar intent, namely authorizing the Veterans' Administration to assist in providing an adequate supply of health manpower for the Nation while improving the quality of care it provides its prime beneficiary, the veteran.

I need not emphasize for this committee the urgency of our health manpower shortages and the need to find innovative solutions. The Senate has reviewed these in detail in considering and enacting the Health Professions Education Assistance and Nurse Training Amendments of 1971, and your statement in the Congressional Record of Thursday, July 22, 1971, summarized the needs and the potential of the VA system in helping meet the needs. I fully share the views expressed in your July 22 statement, Mr. Chairman, including the letters from Dean de Tornyay of the UCLA School of Nursing and Vice Chancellor Grobstein of the University of California, San Diego.

There are several important improvements included in S. 2219 that were not included in Senate Joint Resolution 76. I wish to strongly endorse these:

(1) Accreditation of the professional school or educational institution participating in the program by the recognized accrediting bodies is required;

(2) The affiliations can include not only medical schools, but those in dentistry, nursing, pharmacy, and the other important health professions;

(3) Coordination with the Department of Health, Education, and Welfare is explicitly required in S. 2219 and House Joint Resolution 748, but not in Senate Joint Resolution 76;

(4) Appropriations authorized are $125 million rather than $43 million per year—a more realistic figure in view of the Nation's needs;

(5) Authorization of funds for remodeling of existing VA Hospitals for health manpower education and training, with special allocations authorized for the "Development or initiation of improved methods of education and training which may include the development or initiation of plans which reduce the period required for education and training for health personnel;"

(6) The requirement that the pilot program for assistance in the establishment of new nonprofit medical, health professions, allied health and area health education centers be developed in consultation with the Secretary of Health, Education, and Welfare should reassure those who worry about possible lack of coordination and the several sources of funding for the development of new schools;

(7) The authorization of grants directly to educational institutions should also reassure those who might have some concern if the grants went directly to State government as proposed in Senate Joint Resolution 76 and House Joint Resolution 748; and

(8) The inclusion of area health education centers in the program is also an important addition included in S. 2219. This week, Dr. Charles Carman, associate dean of the University of California, San Francisco, School of Medicine and chief of professional services at Fort Miley Veterans' Hospital, met in Fresno with representatives of the VA Hospital, the VA Central Office, the Department of Health, Education, and Welfare, and all the major institutions in the community concerned with health care, to plan the development of an area health education center in Fresno. The VA Hospital there would be a suitable facility for such a center. This kind of cooperation could be multiplied many fold if this legislation is enacted. Dr. Musser has indicated the approach already initiated cooperatively between VA and HEW.

The new authorities in S. 2219, as do those in House Joint Resolution 748, would stimulate and make possible a full partnership among the Veterans' Administration, educational institutions, and community hospitals and the public that we all serve. They build on the strong and mutually beneficial relationships between the Nation's medical, dental, nursing, pharmacy, and other health professions schools and the Veterans' Administration. The needs and the potential were well described in relation to physicians in House Committee Print No. 14, "History and Potential of Veterans' Administration—Medical School Relationships for Meeting Physician Manpower Needs.", issued on March 11, 1971. The authorizations in S. 2219 meet the needs described in that report and when matched by adequate appropriations, will make a significant contribution to both improving the care for veterans and assisting in meeting our health manpower shortage.

This bill is an excellent complement to the Health Professions Education Assistance Amendments of 1971, and the Nurse Training Act of 1971. They cannot be viewed in isolation because they all contribute significantly to meeting a critical national need.

The Veterans' Administration Health Manpower Training Act (S. 2219) and the Veterans' Administration Medical School Assistance and Health Services Personnel Education Act (House Joint Resolution 748) deal with health manpower needs in a manner suited to the unique resources of the Veterans' Administration. And in a manner that should enhance the basic mission of the VA for providing quality medical and hospital care to veterans. All of the questions suggested at the outset of my testimony, are answered to my full satisfaction in S. 2219. I believe that it contains important provisions not included in House Joint Resolution 748.

I need not remind the chairman what this legislation could mean to the people of California. We have a serious health manpower shortage. We have developed in the University of California, a remarkable and effective partnership with the Veterans' Administration, yet the full potential of this partnership cannot be tapped because of lack of adequate legislative authority and shortages of funds. I am sure that what is true in California is also true in South Carolina and many other States where the VA and our health professions education institutions are working effectively together.

S. 2355: THE VETERANS' ADMINISTRATION CONTINUING MEDICAL EDUCATION ACT

This bill provides the opportunity for Veterans' Administration medical personnel and when staff and facilities are available, medical personnel from other Federal departments and in the general community, to participate in advanced postgraduate programs and continuing education. This is an excellent bill and it provides an important incentive for VA medical personnel to continue their education and thus increase their ability to provide top quality medical services. The scientific base of medicine is continuously advancing as new skills, drugs and technologies are developed and applied. It is no longer possible for physicians to keep current merely by reading and attending short refresher courses and hospital conferences. This proposal will make a career in the VA more attractive to top quality health professionals because it does enhance opportunities for postgraduate and continuing education. My only objection to the proposal is that it does not establish one VA Hospital as a national graduate medical center. This idea has been proposed by Dr. Grey Dimond, provost for the health sciences, University of Missouri at Kansas City. If such a center were located in Washington, D.C., or San Francisco, it could serve as the flagship of the VA Hospital System just as the Bethesda Naval Center, the Walter Reed Army Medical Center, and the Clinical Center of the National Institutes of Health serve as international centers for research, education, and patient care. The VA deserves the same kind of recognition and support. It deserves the same opportunity to provide national leadership.

S. 2354: THE VETERANS' HEALTH CARE REFORM ACT OF 1971

This bill is far more complex than the other bills before the subcommittee. It contains a number of provisions included in the administration's proposed Veterans Medical Care Act of 1971, and it more adequately covers the problems related to nurses employed by the Veterans' Administration than does S. 1635, introduced by Senator Moss.

This bill would improve and expand medical and nursing home care for veterans; provide hospital and medical care to certain dependents and survivors of veterans; provide for improved structural safety of veterans' facilities; enhance the recruitment and retention of career personnel in the Department of Medicine and Surgery; and it would permit sharing of excess hospital beds.

In examining S. 2354, in detail, we kept our first question—How would these new authorities contribute to better patient care?—uppermost in our minds. There may be disagreement over some of the details, but, in the main, this bill goes a long way toward needed reform and it will make a major contribution toward better patient care.

The recruitment and retention of medical, dental, pharmacy, nursing, allied health professions, and health technicians is essential to this task. I will not dwell on details, but we believe all of the provisions under title II are excellent. The provisions in title I simplify the contract provisions, make it easier for patients to be treated on an ambulatory basis and make direct admission to nursing homes possible. The other provisions would correct deficiencies in existing authorities which add to the complexities of administration and impede patient care.

The provisions included in title III, particularly those sections relating to use of excess hospital beds, could be beneficial to both veteran and nonveteran patients.

Let me give one illustration of the possibilities. At the University of California, San Diego, the Department of Psychiatry in the School of Medicine has accepted responsibility for the countywide program of drug abuse and narcotic addiction treatment and rehabilitation. This program is getting underway with a multimodality approach, including medical and psychiatric services. It also calls for some less traditional decentralized community programs, emphasizing group therapy and vocational rehabilitation. Increasing numbers of veteran addicts are being identified. They often first appear at community clinics and they can best be treated and rehabilitated in their own communities.

A limited number of veterans and nonveterans in the program will require intensive inpatient treatment, either psychiatric or medical. In order to accomplish this, the program will incorporate an innovative exchange or sharing relationship which would allow for some veterans and nonveterans in the program to utilize inpatient VA hospital facilities while veterans are taking advantage of clinic, residential, and other facilities outside of the VA system.

When the VA hospital in La Jolla, on the campus of the University of California, San Diego, is completed, it is essential that sharing arrangements be developed so that veterans can get the full benefits of the county funded community based program and all, veteran and nonveteran, who need inpatient services in the VA hospital can have these available. The cost of these facilities and services is too great to duplicate them unnecessarily. If the decentralized approach to treatment is used, many veterans who would otherwise require long periods of inpatient hospital care can be treated at home and in the community, freeing beds for other uses.

This approach has been described by Dr. Arnold Mandell, chairman of the Department of Psychiatry at UCSD, in an article which I would like to submit for the record.

In summary, Mr. Chairman, as a representative of the University of California, I strongly support the three major bills before this subcommittee today: The Veterans' Administration Health Manpower Training Act (S. 2219); the Veterans' Administration Continuing Medical Education Act (S. 2355); and the Veterans' Health Care Reform Act of 1971 (S. 2354).

Together, they would not only correct a variety of deficiencies in existing authority that impede patient care, they should also enhance health professions career opportunities in the VA and expand the authority of the VA to permit the country to realize and make use of the VA's potential in responding to the Nation's health care and health manpower crises.

Most important—these provisions, when adequately supported by appropriations, should significantly enhance the VA's capability of providing high quality medical and other health care services for veterans.

In closing, Mr. Chairman, I want to pay a personal tribute to you and the members of this subcommittee for your continuing concern for the veterans of this country. I feel far more optimistic than I did in December 1969, when my father and I testified before you on the medical care and rehabilitation of Vietnam veterans. At that time, I felt we were not doing what we should or could do. This committee has done much to correct that miserable situation and we are all grateful.

Senator CRANSTON. Thank you, Doctor. Your testimony is most helpful, and I am grateful to you personally, and to the University of California for their assistance, for being with us today. Would you comment on one particular point in Dr. Musser's testimony?

Your comment would be particularly helpful, because of your background in HEW. He was referring to House Joint Resolution 748 and Senate bill 2219, and he said "We feel that the enactment of this legislation would contribute to a fragmentation of authority at a time when the President has emphasized the need for consolidation and coordination of a granting mechanism throughout the Federal Government. Legislation to accomplish this objective is spelled out in the President's health message to Congress of February 18, 1971. It is presently pending before the Congress. Accordingly, VA is opposed to enactment."

Dr. LEE. As former Assistant Secretary in the Department of Health, Education, and Welfare, with responsibility for the programs of health manpower development, including those of medical, dental, osteopathic, pharmacy, veterinary medical education, nurses training and allied health professions education and training, I do not see this as a problem. Rather the problem is the VA lacks authority to fully participate as a partner in this venture. At those universities and schools that work closely with VA, we are seriously limited because of this lack of authority. Because the VA cannot openly and fully participate in the programs and cannot share in the costs of the program.

An example, Dean de Tornyay mentioned in her letter, is the development of nurses training in San Francisco with City College. City College could double its enrollment of associate degree nurses in San Francisco, providing twice as many opportunities mainly for minority students and disadvantaged students to move into a health career if there were adequate clinical and educational facilities. There is potentially space available at the Fort Miley Hospital to do this. The Veterans' Administration is going to be building a new hospital there. The old hospital there will have facilities available that could be used to expand educational programs. Yet the VA doesn't have the authority to do it.

I think you could cite 100 examples from different institutions around the country with this kind of problem related to having adequate authority for the VA to participate in health manpower development programs.

The legislation as it is drafted, I think, would not in any way fragment the programs. I think at the local level, as well as national level, it would improve the Nation's capability of dealing with what is acknowledged to be a most serious national problem. I think the lack of that authority limits use of VA resources. As Dr. Musser said, they could double the number of people trained in VA facilities with additional authorities.

We know that a 20- to 30-percent increase would be possible virtually overnight if authority was available to make these educational facilities and to fund the programs. The authority would do little good without the money.

Senator CRANSTON. You were present through the testimony this morning. Do you have any comment on any other aspects of it?

Dr. LEE. I would certainly share the view you express, Mr. Chairman, that Dr. Musser and Dr. Wells were constrained by the Office of Management and Budget. Having been through that experience myself, I understand that they did not receive a copy of the final testimony until 1:30 a.m. this morning or did not have a chance to go over it until 9 o'clock this morning. That is, I think, indicative of the problems that the professionals are encountering with respect to new legislative efforts. I think, if the administration did not propose it, they will oppose it despite the merits of the particular proposals.

Senator CRANSTON. Do you have any comments on the necessity for more being done in outpatient care?

Dr. LEE. One of the greatest weaknesses now in the whole VA system is care at the outpatient level. Patients have to be hospitalized that need not be hospitalized. Patients cannot receive the care they should, because the authority is lacking to provide that care. Much better comprehensive care could be provided, I think, at considerable cost savings in terms of inpatient services required if it was possible to have the kind of authority that exists in the legislation that is before the committee.

Senator CRANSTON. You indicated earlier in your prepared statement that, while agreeing with the overall thrust of the legislation, you may have some questions about details and some modifying thoughts. Would you submit that for the record?

Dr. LEE. I would be pleased to do so. Mr. Chairman, if I have any specific changes to suggest. Some of those are details that have to be worked out over some period of time and it is hard on first review to give a final judgment about specific levels. But I would say in general, I find very few criticisms with the authorizations and certainly not with the thrust of the legislation.

Senator CRANSTON. Whatever help you could give us as you have time to do it on the details we would appreciate. The record will be open for 2 weeks.

(The prepared statement of Dr. Lee follows:)

STATEMENT OF DR. PHILIP R. LEE, CHANCELLOR, SCHOOL OF MEDICINE, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Mr. Chairman and Members of the Committee. I am pleased to have this opportunity to testify on behalf of the University of California on a series of bills related to improving the ability of the Veterans Administration to provide high quality health services for veterans and enlarging the authority of the Veterans Administration to permit it to assist effectively in meeting the nation's health manpower crisis. The changes proposed in the Veterans Health Care Reform Act of 1971 (S 2354); the Veterans Administration Continuing Medical Education Act (S 2355); and the Veterans Administration Health Manpower Training Act (S 2219) will contribute significantly to the achievement of these objectives.

Although some details may require modification I want to strongly support S 2354, S 2355 and S 2219. These proposals provide needed legislative authority and policy direction that are, in my opinion, urgently needed if we are to provide the veterans of this country with the high quality health care that it is their right to expect.

My major concern, Mr. Chairman, is that funds will not be requested or appropriated to carry out the essential provisions of these proposals. Members of this subcommittee have worked tirelessly and effectively to increase the appropriations for the VA hospital and medical care programs this year and last year. The results, in terms of the fiscal year 1971 budget, were not entirely satisfactory. This year a great deal of progress has been made. This is illustrated by the fact that the fiscal year 1972 appropriations bill now contains $204.1 million more than was in the President's budget. These funds are absolutely essential if the VA is to maintain and improve the quality and scope of health care it provides veterans.

In examining the major proposals (S 2354, 2355 and 2219) before you, I believe there is one basic question that must be answered: what will this legislation do to enhance the quality of medical and other health services for veterans?

A series of related questions must also be answered:

What will the proposals do to make the best use of VA resources in dealing with the nation's twin crises in health manpower and health care?

What will the proposals do to stimulate innovation and improvements in education and patient care?

What assurance is there of cooperative efforts among the various Federal agencies concerned with health manpower, health facilities and health care, particularly the Veterans Administration and the Department of Health, Education, and Welfare?

In this subcommittee's hearings in April, Mr. Chairman, you dealt in great detail with the problems of the quality of medical and hospital care in VA hospitals and clinics. You also considered testimony relating to the potential of the Veterans Administration, in cooperation with the nation's educational and health care institutions, to help us meet our growing health manpower and health care crises. I will not dwell on the details of those informative hearings, except to note that a number of serious deficiencies were identified. Some of these required adequate appropriations to correct. For others, new legislative authority was clearly required. I believe the proposals included in the bills before this committee correct the major deficiencies in legislative authority that were identified.

Let me turn now to comment on the specific proposals.

S. 2219: VETERANS ADMINISTRATION HEALTH MANPOWER TRAINING ACT

This is an excellent bill and I wish to strongly endorse the three major authorities provided:

1. Provision for expansion of existing Veterans Administration hospital education and training capacity;
2. Authority to conduct a pilot program to aid in the establishment of ten new public, nonprofit institutions which may be medical, health professional or allied health schools or area health education centers operated in conjunction with Veterans Administration facilities, and
3. Authority to award grants to medical and other health professions and allied-health schools which are affiliated with VA medical facilities for programs to expand and increase their capacity to train health manpower.

We believe that S. 2219 is a definite improvement over House Joint Resolution 748. The House passed resolution, however, is an important step forward, and I am certain that whatever differences ultimately exist can be resolved.

Although these proposals differ in detail they all share a similar intent, namely authorizing the Veterans Administration to assist in providing an adequate supply of health manpower for the nation while improving the quality of care it provides its prime beneficiary, the Veteran.

I need not emphasize for this committee the urgency of our health manpower shortages and the need to find innovative solutions. The Senate has reviewed these in detail in considering and enacting the Health Professions Educational Assistance and Nurse Training Amendments of 1971.

There are several important improvements included in S. 2219 that were not included in Senate Joint Resolution 76. I wish to strongly endorse these:

1. Accreditation of the professional school or educational institute participating in the program by the recognized accrediting bodies is required;

2. The affiliations can include not only medical schools but those in dentistry, nursing, pharmacy and the other important health professions;

3. Coordination with the Department of Health, Education and Welfare is explicitly required in S 2219 but not in Senate Joint Resolution 76;

4. Appropriations authorized are $125 million rather than $15 million per year—a more realistic figure in view of the nation's needs;

5. Authorization of funds for remodeling of existing VA hospitals for health manpower education and training, with special allocations authorized for the "development or initiation of improved methods of education and training which may include the development or initiation of plans which reduce the period required for education and training for health personnel;"

6. The requirement that the pilot program for assistance in the establishment of new nonprofit medical, health professions, allied health and area health education centers be developed in consultation with the Secretary of Health, Education, and Welfare should reassure those who worry about possible lack of coordination and the several sources of funding for the development of new schools;

7. The authorization of grants directly to educational institutions should also reassure those who might have some concern if the grants went directly to state government as proposed in Senate Joint Resolution 76, and

8. The inclusion of area health education centers in the program is also an important addition included in S 2219. This week Dr. Charles Carman, Associate Dean of the University of California, San Francisco, School of Medicine and Chief of Professional Services at Ft. Miley Veterans Hospital, met in Fresno with representatives of the VA Hospital, the VA Central Office, the Department of Health, Education and Welfare, and all the major institutions in the community concerned with health care, to plan the development of an area health education center in Fresno. The VA hospital there would be a suitable facility for such a center. This kind of cooperation could be multiplied many fold if this legislation is enacted.

The new authorities in S 2219 would stimulate and make possible a full partnership among the Veterans' Administration, educational institutions and community hospitals and the public that we all serve. They build on the strong and mutually beneficial relationships between the nation's medical, dental, nursing, pharmacy and other health professions schools and the Veterans, Administration. The needs and the potential were well described in relation to physicians in House Committee Print No. 14, "*History and Potential of Veterans' Administration—Medical School Relationships for Meeting Physician Manpower Needs,*" issued on March 11, 1971. The authorizations in S 2219 meet the needs described in that report and when matched by adequate appropriations, will make a significant contribution to both improving the care for veterans and assisting in meeting our health manpower shortage.

This bill is an excellent complement to the Health Professions Education Assistance Amendments of 1971 and the Nurse Training Act of 1971. They cannot be viewed in isolation because they all contribute significantly to meeting a critical national need.

The Veterans' Administration Health Manpower Training Act (S 2219) deals with health manpower needs in a manner suited to the unique resources of the Veterans' Administration, and in a manner that should enhance the basic mission of the VA of providing quality medical and hospital care to veterans. All of the questions suggested at the outset of my testimony, are answered to my full satisfaction in this bill.

I need not remind the Chairman what this legislation could mean to the people of California. We have a serious health manpower shortage. We have developed in the University of California and in the private medical and dental schools in California, a remarkable and effective partnership with the Veterans' Administration, yet the full potential of this partnership cannot be tapped because of lack of adequate legislative authority and shortages of funds. I am sure that what is true in California is also true in South Carolina and many other states where the VA and our health professions education institutions are working effectively together.

S 2355: THE VETERANS' ADMINISTRATION CONTINUING MEDICAL EDUCATION ACT

This bill provides the opportunity for Veterans' Administration medical personnel and when staff and facilities are available, medical personnel from other federal departments and in the general community, to participate in advanced postgraduate programs and continuing education. This is an excellent bill and it provides an important incentive for VA medical personnel to continue their education and thus increase their ability to provide top quality medical services. The scientific base of medicine is continuously advancing as new skills, drugs and technologies are developed and applied. It is no longer possible for physicians to keep current merely by reading and attending short refresher courses and hospital conferences. This proposal will make a career in the VA more attractive to top quality health professionals because it does enhance opportunities for postgraduate and continuing education. My only objection to the proposal is that it does not establish one VA hospital as a national graduate medical center. This idea has been proposed by Dr. Grey Dimond, Provost for the Health Sciences, University of Missouri at Kansas City. If such a center were located in Washington, D.C. it could serve as the flagship of the VA hospital system just as the Bethesda Naval Medical Center, the Walter Reed Army Medical Center and the Clinical Center of the National Institutes of Health serve as international centers for research, education and patient care. The VA deserves the same kind of recognition and support. It deserves the same opportunity to provide national leadership.

S. 2354: THE VETERANS HEALTH CARE REFORM ACT OF 1971

This bill is far more complex than the other bills before the subcommittee. It contains a number of provisions included in the Administration's proposed Veterans Medical Care Act of 1971 and it more adequately covers the problems related to nurses employed by the Veterans Administration than does S 1635 introduced by Senator Moss.

This bill would improve and expand medical and nursing home care for veterans; provide hospital and medical care to certain dependents and survivors of veterans; provide for improved structural safety of veterans' facilities; enhance the recruitment and retention of career personnel in the Department of Medicine and Surgery; and it would permit sharing of excess hospital beds.

In examining S 2354 in detail we kept our first question—how would these new authorities contribute to better patient care?—uppermost in our minds. There may be disagreement over some of the details, but, in the main, this bill goes a long way toward needed reform and it will make a major contribution toward better patient care.

The recruitment and retention of medical, dental, pharmacy, nursing, allied health professions and health technicians is essential to this task. I will not dwell on details but we believe all of the provisions under Title II are excellent. The provisions in Title I simplify the contract provisions, make it easier for patients to be treated on an ambulatory basis and make direct admission to nursing homes possible. The other provisions would correct deficiencies in existing authorities which add to the complexities of administration and impede patient care.

The provisions included in Title III, particularly those sections relating to use of excess hospital beds, could be beneficial to both veteran and nonveteran patients.

Let me give one illustration of the possibilities. At the University of California, San Diego, the Department of Psychiatry in the School of Medicine has accepted responsibility for the county-wide program of drug abuse and narcotic addiction treatment and rehabilitation. This program is getting underway with a multi-modality approach, including medical and psychiatric services. It also calls for some less traditional decentralized community programs, emphasizing group therapy and vocational rehabilitation. Increasing numbers of veteran addicts are being identified. They often first appear at community clinics and they can best be treated and rehabilitated in their own communities.

A limited number of veterans and nonveterans in the program will require intensive inpatient treatment, either psychiatric or medical. In order to accomplish this the program will incorporate an innovative exchange or sharing relationship which would allow for some veterans and nonveterans in the program to utilize inpatient VA hospital facilities while veterans are taking advantage of clinic, residential and other facilities outside of the VA system.

When the VA hospital in La Jolla, on the campus of the University of California, San Diego is completed it is essential that sharing arrangements be developed so that veterans can get the full benefits of the county funded community based program and all, veteran and nonveteran, who need inpatient services in the VA hospital can have these available. The cost of these facilities and services is too great to duplicate them unnecessarily. If the decentralized approach to treatment is used many veterans who would otherwise require long periods of inpatient hospital care can be treated at home and in the community, freeing beds for other uses.

This approach has been described by Dr. Arnold Mandell, Chairman of the Department of Psychiatry at USCD, in an article which I would like to submit for the record.

In summary, Mr. Chairman, as a representative of the University of California, I strongly support the three major bills before this subcommittee today: The Veterans Administration Health Manpower Training Act (S 2219); the Veterans Administration Continuing Medical Education Act (S 2355); and the Veterans Health Care Reform Act of 1971 (S 2354).

Together they would not only correct a variety of deficiencies in existing authority that impede patient care, they should also enhance health professions career opportunities in the VA and expand the authority of the VA to permit the country to realize and make use of the VA's potential in responding to the nation's health care and health manpower crises.

Most important—these provisions, when adequately supported by appropriations, should significantly enhance the VA's capability of providing high quality medical and other health care services for veterans.

In closing, Mr. Chairman, I want to pay a personal tribute to you and the members of this subcommittee for your continuing concern for the veterans of this country. I feel far more optimistic than I did in December, 1969 when my father and I testified before you on the medical care and rehabilitation of Vietnam Veterans. At that time I felt we were not doing what we should or could do. This committee has done much to correct that miserable situation and we are all grateful.

THE MULTI-MODALITY NARCOTICS AND DRUG ABUSE PROGRAM FOR VETERANS PROPOSED TO BEGIN DEVELOPMENT ON JULY 1, 1971

(Arnold J. Mandell, VAH, San Diego)

A number of social and historical variables have come together in the Department of Psychiatry at UCSD and in the La Jolla VA Hospital's Psychiatry Division that make it both useful and productive that we begin to involve ourselves in a Drug Abuse and Narcotics Treatment Program for Veterans several months before the La Jolla VA Hospital is due to open. Due to the symmetry of the academic year and the necessity for beginning both residents and some faculty on July 1st of 1971, it becomes necessary to programmatically plan for and account for the time and use of professional staff and faculty as would be justifiable within the context of a Veterans Administration health delivery system. In addition, our department is heavily weighted with a wide variety of drug abuse talent and we have evolved over the last two years a multi-centered, multimodality narcotics treatment program which will eventually be carried out in four centers throughout urban San Diego as well as a 450-acre intensive treatment and long-term rehabilitation center in San Diego North County. This joint project of the Department of Psychiatry at UCSD and the San Diego County makes it possible for us to offer to veterans, beginning very soon, a wide variety of programs in drug abuse and narcotics treatment. These will vary from various kinds of abstinence programs with group and individual psychotherapy, various kinds of psychotherapy drugs as necessary and long-term residential self-help and rehabilitative cultural enrichment experiences in our long-term center. Using other techniques, reversals of the hypomotivated states from long-term marijuana and hallucinogen use can be treated with group work and some new psychopharmacological treatments we are working on.

In addition, methadone maintenance treatment is now ongoing in San Diego County and available throughout the County through our system and can be available to Veterans Administration Hospital patients. There is no comparable multi-modality broadly based drug abuse and narcotics addiction treatment program available in Southern California. For this reason, it seems eminently practical on the basis of "Regionalization" in the Veterans Administration Hospital, that we take on this kind of project. Supportive material documenting our work thus far, the plans, the facility uses, the staff and the faculty, have been enclosed as addenda for reference. We would like to set up a mechanism by which for the first six months before the hospital opens, the residents' stipends and the professional staff hired will be justified on the basis of planning and health delivery in narcotics addiction and drug abuse for veterans. Following the opening of the hospital and the continuation of veterans patients within our out-of-the-hospital multi-centered, multi-modality treatment method, we would like to exchange patient days in our day hospital or patient days in our residential treatment setting and clinic visits for non-veteran placements for either: (1) a small catchment area backup inpatient ward for North County of a general psychiatric nature involving 10–12 beds or; (2) patient-day exchanges for research programs involving, for example, alcoholic and depressive patients who are non-veterans (i.e., middle-aged women).

Exact details of patient registration and other aspects of the bookkeeping in a program of this sort in relationship to the Veterans Administration would have to be negotiated. We have, however, a very careful screening and program monitoring strategy which involves urines, weekly rating forms and psychological inventories that keep track of all our patients and carefully document the amount, number, and extent of our contacts. It would seem to me a generally reasonable concept that VA narcotics addicts (for whom comparable facilities are not available anywhere else in the Southern California region), would begin being treated in July of 1971 in our system. We would keep track of these patient days to justify the consultative and service work of the residents and staff who the Veterans Hospital are paying for during the first six months of the development of our Psychiatric Hospital's staffing pattern. Following this six months (when in fact professional and resident staff activity no longer need to be justified and their work wil continue in the hospital with normal Veterans Administration Hospital work) we would begin to use some sort of sharing arrangement in which we would want in exchange for our treatment of veterans in our extensive narcotics and drug abuse treatment system, some help with our most pressing needs:

1. Permission to use one small 15-bed unit as an inpatient backup facility for a Beach and North San Diego County supported Catchment Area Psychiatric facility. These beds would be supplied by the exchange or sharing arrangements and those that are not supported by such maneuvers would be paid for by the County on a daily rental basis.
2. The second need which is as yet unspecific would be a limited amount of flexibility for our alcoholism treatment and research unit or our affect treatment and research unit (which will be handling for the most part veterans) to be able to study new kinds of treatment with an occasional patient who is not a veteran. Since we won't be rushing into this latter sharing arrangement immediately, we will give Veterans Administration a chance to see what is being done for the veterans in our Drug Abuse and Narcotics Treatment System and to what extent such innovative sharing arrangement might be reasonable and defensible from the standpoint of the veterans' health needs in this area.

We would treat the veterans as regular members of an appropriate patient group in our narcotics addiction and drug abuse system. They would be incorporated into one or another of our programs depending upon their clinical needs. We would locate their major source of service in an area relevant to their geographic location in San Diego County.

The following is a general description of our program and facilities as well as our FDA-IND plan for Methadone treatment and our plans for a long-term residential facility. We are currently developing this facility and it seems entirely possible that a small but significant number of veterans be included in the program by late next summer. Since narcotics addiction and drug abuse has apparently become a primary source of trouble in the Armed Services and among veterans (although I am not sure about the legal status of veterans vis-a-vis the acknowledgment of this problem) and because the veterans' interests are so strongly represented in San Diego County, it seems to be one of those ideal places and times for such a University-Community-Veterans Administration arrangement.

THE SOCIOLOGY OF A MULTI-MODALITY STRATEGY IN THE TREATMENT OF NARCOTICS ADDICTS

If one reviews the medical literature early in the nineteen hundreds on the subject of pneumonia, it is clear that there was a wide diversity of opinions concerning the treatment strategies of choice. The debates frequently had to do with the appropriate temperature of the sick patient's room, the use of chronic versus intermittent mustard plasters, recommendations as to the nursing strategies before, during, and after the crisis, and ideas as to the appropriate clinically defined subgroups to which the various treatment strategies were best applied.

As might be expected with the great limitation in knowledge of both etiology and treatment of this disease, there arose very spirited political positions as to the appropriate treatment strategies. Various professors of medicine from different schools in Europe and this Country maintained and taught different positions as to the treatment of choice. Following the remarkable revolution in bacteriology and chemotherapy relevant to the development of specific treatment for bacterial infections in the last several decades, we look back on such arguments as amusing. Yet, we might be able to learn something from the sociology of this early medical knowledge in that it demonstrates that when human suffering combines with professional ignorance and the expectation of expertise by the patient, there inevitably arises superstition and politicized organization of the so-called body of knowledge within which the delivery of health care in such an area must go on.

The delivery of mental health care services over the past several hundred years would certainly appear at different times and places to be directly analogous to our pneumonia model. This appears to be the case from the early days when deviant behavior was considered to be a sign of malfunction of the spirit generated by the devil to the present day when behavioral deviance and subjective suffering is attributed to the complicated interaction of nebulously characterized internal processes. When attempting to treat psychiatric syndromes, we are caught in a welter of partially substantiated historical tradition, currently operative value systems, factors having to do with professionalism and almost trade unionism, and sociopolitical forces that have become invested in the power (financial or otherwise) engendered by the creation and running of mental health treatment programs. Certainly the current zeitgeist in the treatment of the narcotics addict is in such a conflictual state. It appears that a number of vested interests are fighting over the junkie.

The Justice Establishment with its extensive parole, probation, and incarcerative treatment programs appeal to the anxiety and righteous wrath of the populace in asking for more money, larger spheres of influence and greater power not only to help control the supply of illegal drugs but to use their strategies to keep the junkies within their province.

Numerous self-help groups formed initially on the model of Alcoholics Anonymous and evolving to Synanon, Daytop Village, Narcotics Anonymous and numerous indigenous worker staffed and community supported programs have grown like topsy over the past decade. In addition to challenging the mental health profession with new models for effective social rehabilitation and producing a new kind of psychosocial adaptation for a certain subgroup of addicts with abstinence as the focus, they have created their own political action theme in the field of narcotics addiction treatment. Running principally on the "mystique of the dope fiend" (which I am beginning to feel has the same validity as the expectation that a training analyst in fact knows more about people than other people), the self-help movement has pretty consistently attempted to disenfranchise the medical establishment as competent to deal with these problems, created and promoted resistance to pharmacological substitutive or blocking treatment strategies, and via both demonstrated and advertised competence in the area has more or less sold the idea to all of us that the only people who can understand or treat dope fiends are other dope fiends. This latter promotion has led to the creation of a new career ladder for ex-addicts. What has been begun as a rehabilitative effort for ex-addicts appears to be becoming a group with the same needs to maintain the existence of their institution that any other kind of establishment might have. Synanon's way out of the institutional-maintenance demand was to shift formal focus from the dope business to the "people business." Rehabilitation by self-help groups into new careers of creating and maintaining more rehabilitative programs certainly must have a limit.

A third group fighting over the junkies is the medical psychiatric establishment. With the trends in psychiatric treatment moving in the direction of more relevance to community relevance, toward lower socio-economic groups as patients, the incorporation of indigenous workers as mental health care deliverers, and a re-evaluation of professionalism within mental health contexts, it is only natural that many Psychiatry Departments, Community Mental Health Centers, and other such mental health care delivery systems would involve themselves in the treatment of the narcotic addict. It also makes sense, following the brilliant and innovative work of Dole and Nyswander, that the modality pushed by such medical establishments would be a tool with which the doctor feels most comfortable: chemical agents. Agents such as methadone, whether in fact it turns out to be operating by blocking or what appears more likely nowadays by substitution, cyclozazine and other drugs have become the avenue with which the medical establishment have become involved with the treatment of the junkie. Funding for such programs are now, even at a time of short money supply for new programs, available both nationally and locally. A remarkable amount of staff support, research support, and other fringe benefits that come attendant on the organization of narcotics treatment programs within a medical context make the setting up for such organizations very seductive indeed. It is not surprising, therefore, that many of the treatment programs have not asked the question about what is the minimal medical intervention necessary for what outcome (and why should they—either the justice or the self-help establishments have certainly not focused on the treatment evaluation) but rather have funneled narcotics treatment money for use within the context of already existing mental health care delivery systems. Intakes, psychodiagnostics, psychotherapy, group therapy, and rehabilitative efforts have in many instances automatically accompanied drug treatment for addicts. Very recently this kind of system has been challenged by the number of workers, outstandingly Blachly in Oregon, Goldstein in California, as well as some of Jaffe's subgroups in which the question is asked, "What is the minimal interventive effort that can be made by a medical establishment in this regard to achieve cost-benefit analysis justifiable outcomes for the narcotics addicts?" In this time of sagging support for mental health treatment, training, and research programs, it has paid the medical establishment not to ask this kind of question.

Another group that are fighting over the junkies in some locales are the political activists with primary goals of political and financial power for the radicalized segment of one or another ethnic minority. By exploiting the issue of lack of drug treatment facilities and the florid tragedy of the junkie, several significant inroads into mental health establishments, destructive disorganization of establishment power hierarchies, and occasional accession to patronage power has accrued to such groups. As is the case with such a focus by activists, the approximation of the formal goals often leads to more agitation as the institutional maintenance issues triumph over real social concern. The substantive focus of the struggle can vary from the pros or cons of methadone treatment, who controls admission policies, who determines hiring policy for indigenous workers, or whether or not a community group can control the budget. The Yale Community Mental Center is said to have suffered from such a struggle. We at UCSD are just recovering from ours. It is interesting, however, that in most instances, the activists have their own ideas about how treatment should be conducted. The diversity of approaches proposed by these various establishments with a little in the way of hard evaluative data, I'm afraid, characterizes the situation with many problems being handled by mental health care delivery systems. Crisis intervention, psychoanalysis, group therapy. T-groups, and other such interpersonal interventive techniques have suffered from such a lack of treatment evaluation that most intra-modality arguments are made up of platitudes rather than statistics.

I have belabored the sociopolitical aspects of the development of treatment modalities in narcotics addiction as background for my general proposition. The general statement I wish to make is that in order to stimulate, develop, integrate, maintain, and get support for narcotics treatment programs in a scientific and social circumstance as I have described them, it is my feeling that a multimodality treatment system if it is financially feasible is the approach of choice. From our experience over the past several months in San Diego and more significantly, from studying a remarkable system developed by Jerome Jaffe over the past three years in Chicago, I am convinced that it is possible to develop a multimodality treatment system within a single administrative structure and that such a system can reduce or eliminate much of the inefficiency and destructive rivalries between the establishments that I have outlined. In addition, by developing a diverse program, it becomes possible to evaluate outcome and compare efficiencies of modalities in specific communities without operative biases. Over the next few years (in comparison to the past several decades) it will be possible to finally evolve both some idea of the efficacy of the various modalities as well as perhaps and most hopefully specific indications for one or another of them depending upon the type or characteristics of the addict in treatment.

The major underlying assumptions of the multi-modality concept are that we are currently quite ignorant of causes and cures of narcotics addiction and that the relevant variables are probably quite heterogeneous. One, there is a marked heterogeneity in the addict population even in such subgroups as long-term, hard narcotics users. Those who make up the narcotic addict populations clearly have different reasons for initiating drug use, exhibit different patterns of drug use, and have become established in widely differing psychosocial patterns in relationship to their narcotic use. Obviously then, as far as we know at the present time, such a heterogeneous group may require a number of different kinds of treatment and rehabilitative approaches. Two, we assume that there is a heterogeneity of community resources, especially the interests and orientation of various groups concerning the treatment modality of choice. Certainly community support both from the patients and their community as well as the relevant government agency is necessary to be able to create and sustain treatment programs. The multi-modality treatment concept gives some piece of the treatment program with which to identify for most if not all the community groups. The availability of a detoxification and a community run abstinence program in San Diego reduced the paranoid toward our methadone component markedly.

The third kind of acknowledged heterogeneity is that of the goals of narcotics treatment. As is the case with all psychosocial intervention, goals are very much dictated by the ethics and values of the involved society. It is certainly not established what are the desirable goals of a narcotics treatment program. Is it abstinence? Is it social rehabilitation? What kind of social rehabilitation? Is it the reduction of crime? Should we focus on increasing the number of tax paying citizens? Or should the goal of the program be the constructive use of narcotics addiction as a reason for social change in order to ameliorate some of the causes of a psychosocial or socioeconomic sort which may have led to the indigenous narcotics use patterns. There may, in fact, be a choice of goals for some addicts. Recent preliminary findings growing out of our program and more definitive data from Jaffe's work has suggested that the back-to-work goal (the person's old work) may be best promoted by a methadone maintenance strategy. In contrast to this outcome, an abstinence program in therapeutic community with re-entry as a goal may lead to ex-addicts who are engaged in a new career of social action, narcotics program development, or other missionary causes, but who seldom if ever return to their previous socioeconomic arrangement. Such psychosocial character change has been noted in the Alcoholics Anonymous abstinence programs as well. The heterogeneity in available goals may require some difficult sociopolitical decision making. In one instance, the community may desire addicts to return to their old work and generation of taxes whereas another community might regard as valuable the small but significant group of self-help oriented ex-addicts who can lead narcotics treatment and education programs in the community.

The fourth kind of heterogeneity justifying a multi-modality approach is the real difference that may exist in statistical effectiveness of various modalities in different communities. That is, between ethnic groups, socioeconomic groups, geographical areas and communities what is the best treatment? Figures growing out of a uni-modality treatment program like that of Goldstein's in Santa Clara (using methadone alone) say 60% of his patients' urines are clean in six months. I like to ask in comparison to what? Historical controls using law enforcement figures are not the best we can do now. The multi-modality concept allows efficacy comparisons which will lead to programs tailored to the community.

The modalities

The program we are in the process of developing in San Diego is to a certain extent modeled after the one in Chicago with certain interesting and relevant exceptions. Jaffe's program in Chicago has several treatment elements to which patients were initially randomly assigned. These program elements include methadone substitution alone, methadone substitution with group psychotherapy and vocational rehabilitation, outpatient detoxification with a short-term therapeutic community and early reentry rehabilitative program and long-term therapeutic community stay with re-entry a delayed goal. Our program which is modeled after this one, has a methadone maintenance clinic, with and without rehabilitative and psychotherapeutic efforts detoxification in a hospital with follow-up by an independent Chicano group, detoxification in the hospital with therapeutic follow-up in the University program and we are currently developing a therapeutic community. It is interesting that in exploring the specific therapeutic community organization that would be appropriate in San Diego, it became clear that the Chicano addict who represents about 60% of the addict population in San Diego adjusts poorly to a Synanon-type disarticulation from his family and fails to develop a useable new group identification. They refuse to stay away from their families in half-way houses; they tolerate confrontational rhetoric of the sort seen in Synanon Games not at all. The combination of Macho and their dependence on the females in their families require a different kind of rehabilitative institution characterized by more deferential ritual, more respect, and less disarticulation from their mothers and wives. We are currently exploring the possibility of developing a family oriented therapeutic ambience that seems to fit most specifically the psychosocial climate of the Mexican-American addict. We were struck by the fact that Chicano methadone patients frequently brought their wives and children to the clinic and would consider living away only if their primal or secondary family was available to them.

The staff

A word should be mentioned about the development of our narcotics treatment staff. Through the flexibility allowed us by innovative University Personnel Policies, we have been able to attract a number of competent indigenous workers led by David Deitch from Daytop Village. He is busy developing indigenous talent from the community but within the context of our department. We have been able to give job security and professional status to our indigenous workers via the development of new categories of University employees, called Addiction Rehabilitation Counselors, or ARCS. This career ladder has various steps (I, II, III, and IV) and varies from $7,000 a year to about $14,000 in salary. Funding for this program which is channeled through the University comes from various sources including County contracts, State training money, and hopefully, in the not too distant future, staffing money from NIMH. The University-defined job categories produce in addition to an increased sense of job security for these Addiction Rehabilitation Counselors specialists, a fusion with the academic Department of Psychiatry. A fall-out from this kind of enmeshing of talents has been a serious questioning of the professionalism in psychiatry and a growing knowledge on the part of the Residents in training that they will be able to avail themselves in later years of non-professional talent when creating community health delivery programs. It appears that our narcotics treatment staff in relating to our more conventional faculty may lead to a hot bed of innovation in treatment and training in mental health delivery. I can't emphasize too much the remarkable and important humbleness engendered in our residents when they see the sensitive, capable, and effective interpersonal transactions of our indigenous workers. If the narcotics treatment problem gets cleaned up in a significant way in San Diego (where it appears as though it may be of manageable size), we hope to take the same organization and move it into the area of juvenile delinquency, alcoholism and other areas of psychiatric failure.

Procedures and preliminary results

As patients approach us for admission, they are given several interviews and rather extensive evaluation by both professionals and ex-addict indigenous workers focusing on their psychosocial status, the validity of their story, and a discussion with them of their choice of treatment modality. Following this, various treatment programs are instituted and, using regular urine tests and psychosocial inventories, the patients are followed. It appears that thus far in our program, somewhere between 60% and 70% of methadone maintenance patients after three months regularly evidence clean urines. It appears that the back-to-work rate which is about 15% in our methadone patients before treatment moves up to between 50% and 55% within three to six months of instituting treatment. The other extreme in terms of outcome is our hospitalization and detoxification with minimal follow-up (which has been carried out by an autonomous indigenous Mexican-American group who have abstinence as their major goal). Of 65 patients in six months who have been detoxified on our unit and followed by this Mexican-American group, only three remain clean three months later. Our own follow-up and therapeutic community data await further work. In terms of the evaluation of methadone maintenance with and without intrapersonal intervention. I have some very recent data from Jerome Jaffe's program in Chicago which I think is probably relevant. It appears that in his "holding pattern" (methadone only) program, the back to work rate is somewhere between 20% and 25% when studied over six month's time. The back-to-work rate in the methadone program when carried out in collaboration with group meetings several times a week and some available vocational rehabilitation, doubles to about 50%. If this back-to-work rate is associated with the social integrative rehabilitative moves that it is in many other kinds of psychiatric disease, it appears as though more subtle measures might show even more dramatic differences.

The therapeutic community (Synanon-type) issues vis-a-vis abstinence figures is certainly a very loaded question. There is little question that this kind of thing is quite expensive, quite long-term and therefore should be looked at critically with outcome measures. I have recently had the opportunity to visit The Family at Mendocino State Hospital and see their statistics over the past year and a half. The similarity of the statistics to Jaffe's therapeutic community programs is so remarkable in spite of the clearly different geographical, social, and ethnic organization of the data that I thought it would be of interest to you. It appears that in Jaffe's program, of those patients assigned randomly to the therapeutic community modality, only about a third show up to participate. Of those that show up to participate, between 60% and 70% of them split within the first year. Therefore, the figure in terms of retention and abstinence in a therapeutic community is about one-third of one-third or approximately 12% of a general addict population in Chicago. The Family at Mendocino State Hospital with a little bit different arrangement has very similar numbers. Patients originally enter a modified therapeutic community for three months as a test of their motivation. As they enter the authoritarian structure and demands are made on them, close to two-thirds "split." Of the 30% to 35% that go on to The Family, only 40% remain abstinent and affiliated with The Family at the end of the year, that is, therefore 40% of about 35% or approximately the same number 12% to 15%. In a follow-up to The Family, all but three of the 37 graduates last year have gone on to work in other narcotics treatment programs, spawning much of the same kind of programs from which they came. This is true in Jerome Jaffe's program as well in that the abstinent people very often involve themselves in a new career in narcotics treatment and prevention.

As one begins to compare the efficacy of modalities, methadone maintenance with, for example, the very best of the abstinence program in a re-entry oriented therapeutic community, for example, one comes to believe at least in this early stage, that in terms of large population efficacy the methadone program is much preferable to the abstinence programs. On the other hand, I must hasten to add that the kind of addict who successfully participates in Synanon, Daytop Village, or other such therapeutic community programs turns out to be rather valuable indeed, going on to educate, create, and organize in a socially relevant and constructive way. As I noted previously whether in fact when all the numbers are in, governmental agencies or social groups will be willing to support one or another of these programs will have to be seen. Meanwhile, however, we hope to be able to generate statistics to present to such decision-making groups.

As I look over what I have laboriously tried to put together here for you, it sounds in summary quite simple. I think one of the Chicano addicts working in our program put it very simply, saying that there are, "different strokes for different folks." The implications of that simple kind of statement, however, are myriad. The ease with which a multi-modality program can move into a community is so much greater than one or another of a special treatment type. The possibility of a wide variety of modalities reaching different kinds of addicts are very obvious. The gradually being realized hope of finally getting some good comparison figures for any community is emerging. I think that the multi-modality concept is a very defensible approach to narcotics treatment during our time. It brings together doctors, mental health professionals, indigenous groups, community organizations, and government in a very constructive way. Perhaps this kind of program will become a model for more general psychiatric treatment program delivery in the future.

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3. Dole, V. P. and Nyswander, M. A medical treatment for diacetylmorphine (heroin) addiction. *JAMA*, 1965, *193*, 646–650.

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6. Jaffe, J. H. Statement to the United States Senate Special Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare, August 8, 1969.

7. Roberts, A. C., The Family, Personal Communication, 1970.

Senator CRANSTON. The next witness is Dr. William Anlyan, vice president for health affairs of Duke University, Durham, N.C., chairman of the executive council, Association of American Medical Colleges, accompanied by Mr. Prentice Bowsher, of the Association of American Medical Colleges.

I would like to welcome you and thank you for your presence.

Before you start, I want to tell you that the Health Conference is going to be held this afternoon at 2:30 on legislation of great interest to you and others relating, among other things, to aid to medical schools. I am hoping that we can get through so I can attend, because I am very much interested in that legislation, as you are. So we are going to try to move as swiftly as we can and not take any break for lunch. If you could summarize your views and submit the whole prepared statement for the record, I would be grateful.

STATEMENT OF DR. WILLIAM G. ANLYAN, VICE PRESIDENT FOR HEALTH AFFAIRS OF DUKE UNIVERSITY, DURHAM, N.C., CHAIRMAN OF THE EXECUTIVE COUNCIL, ASSOCIATION OF AMERICAN MEDICAL COLLEGES; ACCOMPANIED BY PRENTICE BOWSHER, OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. ANLYAN. Thank you, Mr. Chairman. That was what we had hoped to ask your permission for.

The past record, Mr. Chairman, of our relationship with the VA has been outstanding and very worthwhile.

Currently, there are 81 medical schools that are affiliated with VA hospitals and 31 percent of our students receive part of their education in the VA hospitals. But I have to be very candid with you in my remarks that at the present time the level of care in the VA hospital, affiliated with the university, is at a considerably lower level than in the university hospital across the street. The VA hospital affiliated with the university has not kept up in the development of sophisticated medical care, subspecialized care. There is a grave need for increasing the sharing of resources as well as the resources in the VA.

You have brought up in the morning testimony the matter of the outpatient clinic. Here is an area where the affiliated hospital and the university hospital could share not only the operating costs, but also in the capital costs. Unfortunately, today there is no authority for the VA to participate in the construction costs of the joint facility. So that overcrowding, understaffing, deteriorating physical facilities, obsolescent equipment, are part of what the problem is in giving a lower level of medical care to the veterans in the affiliated hospital.

With regard to the specific legislation that is proposed, we feel that the new schools should be located where there can be maximum benefit for the health care of the Nation along the lines of the prestigious Carnegie Commission report. If an unaffiliated hospital happens to fit those criteria, then we feel that it could be developed into a potential academic medical center, but it is very important to have the potentially affiliated hospital near a university, because it would be difficult to attract faculty, particularly in the basic medical sciences, to a medical college that is far apart from a university.

The association was concerned about the fragmentation of Federal support for medical education, and I think that your bill, Mr. Chairman, takes cognizance of that in coordinating with HEW.

We are also in support of your bill, because it provides maximum coordination between the VA and HEW. It has maximum flexibility of funding at more realistic levels. It imaginatively broadens the two programs to include the area of the health education center concept of the Carnegie Commission, and the assurance that the new schools would meet the appropriate accreditation standards. It also provides funding for remodeling and construction. There are still some serious limitations.

(1) The patient population is limited because of the older age males with chronic illness, even though 14 percent of the population are Vietnam veterans. The lack of ambulatory-care facilities and the lack of responsiveness to new developments is a major concern in the affiliated VA hospital. The association is encouraged by your bills, particularly S. 2354 and S. 1924, in improving the type of care of the patients in the VA hospital and in expanding the ambulatory care. We feel that S. 2355 is an important step forward.

I was particularly interested in your comment about upward and lateral mobility. We could, if you wish, Mr. Chairman, submit for the record a model program that we have developed in the past 2 years at Duke University, called Paths for Emloyee Progress, whereby we share as an institution the cost of upward mobility for education with the employee. This model program could be adaptable to the VA system so that the subprofessionals would not be lost from the system, as was brought out in the testimony this morning.

Senator CRANSTON. Please submit that. That would be helpful to us.

(The material subsequently supplied follows:)

I. TOTAL EMPLOYEE PARTICIPATION

(Narrative Summary)

A. Total contacts by employees visiting the office and completing a pre-application card and/or a PEP application	544
1. Present, active applicants who are seeking admission into health related educational programs with PEP support	188
2. Inactive applicants (are not interested in going to school or not qualified for PEP help at this time or are no longer employees at Duke, etc.)	232
3. Employees presently in school as full-time students with PEP financial support and related services*	56
4. Graduates who went to school with PEP financial support and related services	28
5. Non-graduate employees who received PEP financial support and/or supportive services (includes employees presently working on high school completion, dropouts, etc	40

*Related services includes counseling, monitoring work performance, tutorial help if needed, and referral services.

II. DISTRIBUTION BY INSTITUTION AND AREA OF STUDY FOR PRESENT PEP EMPLOYEE-STUDENTS WITH PROJECTED GRADUATION DATES

Institution	Area of study	Number enrolled	Number of dropouts	Expected graduation
Durham Technical	Practical nursing education, 1st quarter	8	0	February 1972.
Do	Practical nursing education, 2d quarter	2	0	November 1971.
Do	Practical nursing education, 3d quarter	16	4	August 1971.
Do	Inhalation therapy	3	0	May 1972.
North Carolina Central University	Bachelor of science in nursing, freshman year.	15	1	May 1974.
Do	Bachelor of science in nursing, sophomore.	4	0	May 1973.
Do	Bachelor of science in nursing, junior year.	1	0	May 1972.
Duke Medical Center	Physician's assistant	3	1	July 1972.
Do	Audio-visual education and Medical Illustration	1	1	January 1972.
University of North Carolina	Bachelor of science in nursing, freshmen.	1	0	May 1974.
University of North Carolina-Correspondence.	Dental assistant	1	0	May 1972.
Durham Technical Institute	Electronic engineering technology	1	0	May 1972.

III. DISTRIBUTION BY EDUCATIONAL PROGRAMS REQUESTED[1]

Educational program	PEP participants in school	Graduates	Active pending applicants	Inactive applicants
Patient care assistant II	0	21	11	15
Licensed practical nursing	26	1	54	30
Advanced licensed practical nursing	0	0	7	1
Bachelor of science in nursing	21	0	44	22
Medical office training	0	4	15	14
Inhalation therapy	3	0	1	6
Operating room technology	0	0	0	2
Radiological technology	0	0	5	3
Pathology assistant	0	0	1	0
Physician's assistant	3	1	5	12
EEG	0	0	6	5
Other	3	1	37	122
Total	56	28	186	232

[1] This chart shows in which programs employees are participating, the programs desired by ''pending active applicants'', and the programs desired by ''inactive applicants''. An example: On the first line, there are 0 participants in patient care assistant II level training at this time. There have been 21 graduates from patient care assistant II level training. There are 11 ''pending active applicants'' who desires patient care assistant II level training and there were 15 ''inactive applicant '' who wants patient care assistant II level training.

IV. JOB PROGRESSIONS FOR GRADUATES

Previous job	Present job	Institution	Area of study	Dates in school
Messenger	Clerk typist	Training center	Basic secretarial skills.	Aug. 10, 1970 to Sept. 25, 1970.
Dietetics supervisor	Secretary I	do	do	Do.
Patient care, assistant I.	Patient care, assistant II.	Duke Medical Center.	Patient care training.	Jan. 25, 1971 to Feb. 26, 1971.
Clinical assistant	Clinical assistant II	do	PCA II training	Do.
Messenger (urology)	PCA II	Durham Technical Institute.	do	June 1, 1970 to Aug. 14, 1970.
PCA I	PCA II	Duke Medical Center.	do	Jan. 25, 1971 to Feb. 26, 1971.
Housekeeping	PCA II	Durham Technical Institute.	do	June 1, 1970 to Aug. 14, 1970.
PCA I	PCA II	Duke Medical Center.	do	Jan. 25, 1971 to Feb. 26, 1971.
PCA I	PCA II	do	do	Jan. 11, 1971 to Jan. 22, 1971.
PCA I	PCA II	do	do	Jan. 25, 1971 to Feb. 26, 1971.
Clinical assistant I	Clinical assistant II	do	do	Jan. 28, 1971 to Feb. 26, 1971.
CA I	do	do	do	Jan. 11, 1971 to Jan. 22, 1971.
PCA I	do	do	do	Do.
LPN	Physician's assistant	do	PA program	June 1, 1970 to Sept. 4, 1970.
PCA I	PCA II	do	PCA II training	Jan. 11, 1971 to Jan. 22, 1971.
PCA I	PCA II	do	do	Do.
PCA I	PCA II	do	do	Do.
Clinical assistant I	Clinical assistant II	do	do	Jan. 25, 1971 to Feb. 26, 1971.
Do	do	do	do	Do.
Do	do	Durham Technical Institute.	do	Sept. 2, 1970 to Nov. 24, 1970.
Ward clerk	Secretary I	Training center	Basic secretarial skills.	Aug. 10, 1970 to Sept. 25, 1970.
Dietetics		do	do	Do.
PCA I	PCA II	Duke Medical Center.	PCA II training	Jan. 25, 1971 to Feb. 26, 1971.
PCA I	PCA II	Durham Technical Institute.	do	June 1, 1970 to Aug. 14, 1970.
PCA I	PCA II	Duke Medical Center.	do	Jan. 25, 1971 to Feb. 26, 1971.
Nurse technology	RN	do	Psychiatry	Nov. 30, 1970 to Mar. 5, 1971.
PCA III	LPN	Durham Technical Institute.	LPN training	Mar. 3, 1970 to Feb. 25, 1971.
PCA I	PCA II	Duke Medical Center.	PCA II training	Jan. 11, 1971 to Jan. 22, 1971.

V. SEX AND RACE DISTRIBUTION

Race	Sex		
	Female	Male	Total
PEP participants in school:			
Black	37(.66)	7(.13)	44(.79)
White	9(.16)	3(.05)	12(.21)
Total	46(.82)	10(.18)	56(1.00)
Pending applicants (percent):			
Black	76	12	88
White	11	1	12
Total	87	13	100

VI. FINANCIAL AID NOTES

1. PEP was allocated $141,185 in the fiscal year 1971 for student assistance (stipends, tuition, fees, tutorials).

2. PEP has committed and/or encumbered approximately $122,000 of the allocated funds for financial aid for 124 employees. The 124 employees include dropouts, tutored students and others.

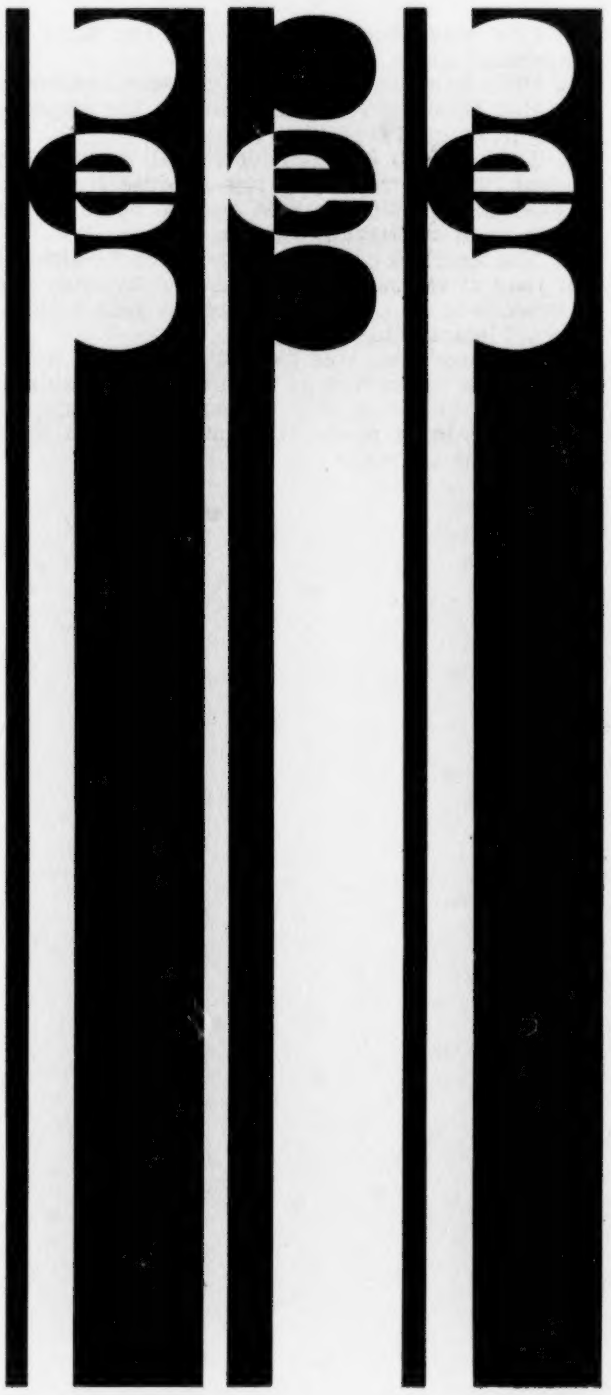
3. The average cost considering all employee-students assisted is $975.00 per student. This is relatively low because it does include employees who did not succeed and employees who receive some of their financial aid from outside sources such as veterans benefits, etc.

4. The average cost per student for Licensed Practical Nurse Training (one full year of school) is $1,915.08. The average cost per student for the Bachelor of Science in Nursing Education (4 year college degree program) is $2,439.00, does not include outside sources.

5. PEP has been able to capitalize on its allocated funds for financial aid by insisting on utilization by employees of outside funds such as veterans benefits. Also, PEP has been able to coordinate some short-term training within Duke to meet training needs at a low cost than would be incurred if the training were outside of Duke.

Paths for Employee Progress

Duke University
Medical Center



Mr. Howard N. Lee, PEP Director and Assistant to the Director of Medical Education

Mr. Kenneth P. Lineberger, PEP Coordinator
Mrs. Linda Darsie, PEP Roving Counselor
Miss July McCoy, PEP Roving Counselor
Miss Sylvia Parker, Secretary
For more information call 684-6343

Duke University, as an educational-medical complex, has as one of its primary commitments unexcelled educational advancement. Underlying this commitment is the educational advancement of Duke employees themselves.

Through the Paths for Employee Progress (PEP) program, employees can learn about, and take advantage of, the educational opportunities available to them. In addition to ensuring that interested employees will be given the opportunity to advance themselves educationally, PEP is designed to increase the possibilities of upward mobility in the health field.

PEP may help employees interested in education in several ways. First, PEP has identified and coordinated information about many of the health-related programs at the Duke University Medical Center and at surrounding hospitals and schools. On file in the PEP office is information about admission requirements, starting dates, length of programs, costs, and other details about the programs. Many of the available programs are outlined in this brochure, and more complete information can be obtained in the PEP office.

Those seeking admission into these programs should contact the PEP office. The PEP staff can answer preliminary questions about admission and guide employees through the admission process. All applicants will be considered without regard to race, color, religion, sex, or national origin. Application forms for some of the programs are on file in the PEP office.

Employees should bear in mind that PEP itself does not guarantee or assure admission into specific programs. The admission decision rests with the schools or programs involved. Every effort will be made, however, to help prepare an employee for successful admission.

One of PEP's main objectives is to remove financial barriers for employees who go to school full time. Various plans of financial assistance are offered through PEP to employees who participate in the program. Financial assistance is determined on an individual basis, according to the program costs and an individual's economic situation. Some employees have financial resources, such as the G.I. Bill, which are considered when PEP financial assistance is formulated.

PEP's services continue while employees attend school. Counseling and referral services are furnished to those who encounter problems while they are in a program or being trained.

To be eligible to participate in PEP's program, an employee should have worked at Duke for one year. This does not mean, however, that employees must work for a year before contacting PEP to make future plans.

Interested employees should complete an application in the PEP office and give PEP staff members an opportunity to talk personally with them and to obtain some information about their plans and goals.

PEP's goal is your success, because the success of Duke employees means the continuing progress of the University and the hospital.

OPPORTUNITIES FOR CAREER ADVANCEMENT

Advanced Licensed Practical Nursing

This program offers licensed practical nurses further instruction in patient care. Team leadership, medication, and nursing care are the areas of concentration in this training program.

Participants receive six months of on-the-job training in the Duke University Medical Center and gain experience in directing patient care as team leaders or as charge nurses in the absence of registered nurses. Along with advanced practical experience, courses in this program include anatomy, physiology, nursing care, pharmacology, and ward management.

Admission Requirements

1) Submit an application to Patient Care Education for Nursing Service
2) Submit a licensed practical nurse transcript to Patient Care Education for Nursing Service
3) Testing by Patient Care Education for Nursing Service
4) Three recommendations and the recommendation of supervisor

Bachelor of Science in Nursing

The baccalaureate degree program in nursing provides qualified high school graduates with the opportunity to study nursing in a college or university setting.

Graduates of baccalaureate degree programs are prepared as practitioners of professional nursing to give nursing care to people in various settings, and to interpret and demonstrate such care of others. As professional nurses, they have basic competence in planning, directing, and evaluating the outcomes of nursing care given by associated personnel working with them.

There are B.S.N. programs offered at North Carolina Central University in Durham, the University of North Carolina at Chapel Hill, and Duke University. Admissions requirements vary; therefore, each school should be contacted for specific information.

Admission Requirements
1) High school graduate (with college preparation courses)
2) Scholastic Aptitude Test of the College Entrance Examination Board (SAT)
3) Good physical and mental health
4) Personal interview

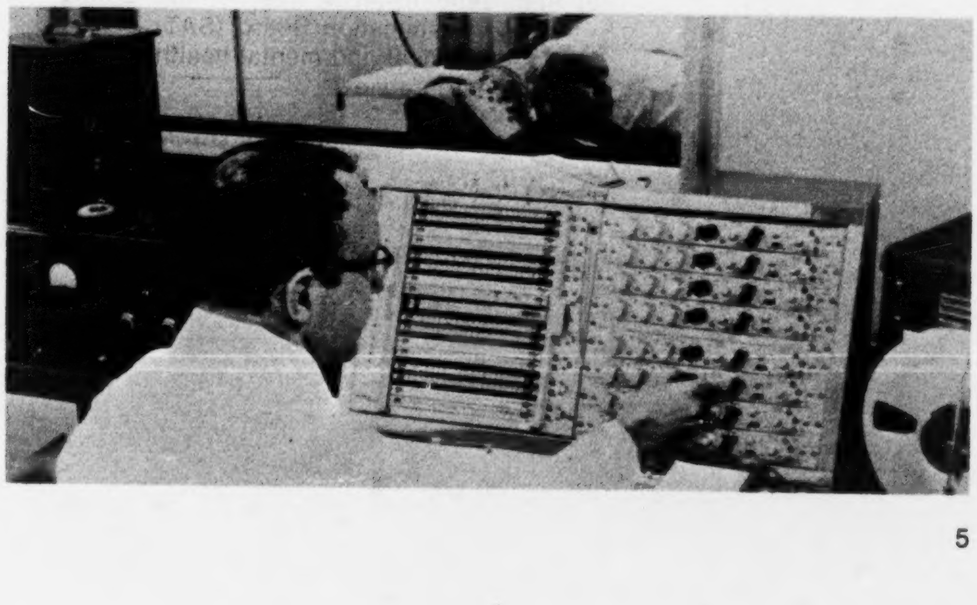
EEG Training Program

The Duke University Medical Center offers a six-month course in EEG (electroencephalograph) training. Studies include background in neuroanatomy, neurophysiology, neuropathology, psychiatry, and neurosurgical lectures; courses in practical EEG techniques and electrode application; EEG technology and interpretation; and on-the-job training. Completion of the course prepares EEG technicians capable of performing in any EEG laboratory situation.

The course begins in January and July for a limited number of students.

Admission Requirements

1) Application
2) High school graduate or high school equivalency (one or two years of college preferred)
3) Personal interview
4) Three references



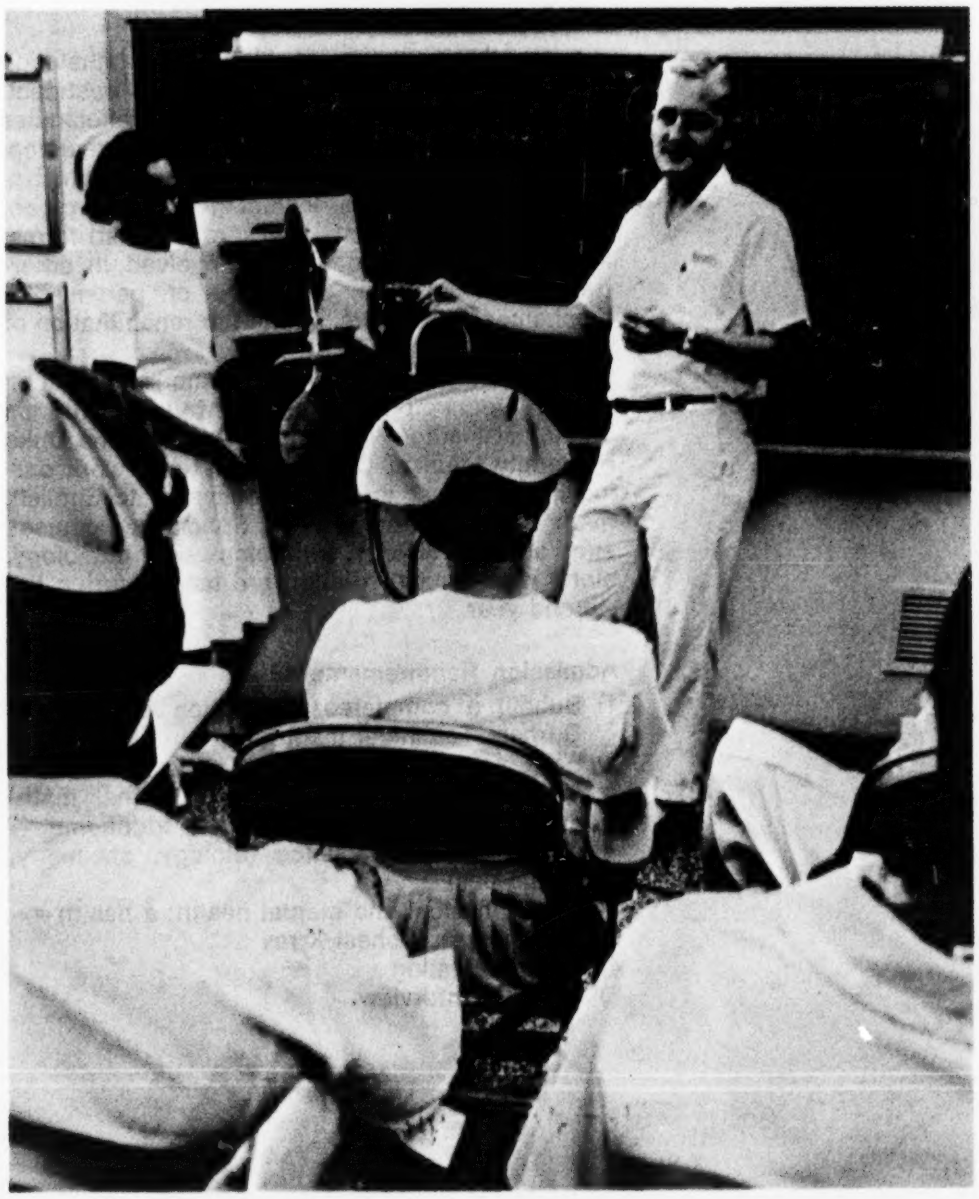
Inhalation Therapy Technology

An allied health specialist, the inhalation therapy technician is employed in the treatment, control, and care of patients with deficiencies and abnormalities associated with breathing. These technicians are trained in the administration of medical gases, including air and oxygen, drugs and medications, and aerosol (mist) forms. In addition, they are directly involved in emergency resuscitation, the care of patients in mechanical ventilators, and in the rehabilitation of patients with lung diseases.

The two-year training program in inhalation therapy technology is offered by the Durham Technical Institute in coordination with the Duke University Medical Center. Classroom work during the first year is devoted primarily to English, math, chemistry, and physics. Specialized courses such as microbiology, physiology, and pathology, along with clinical rotation are taught during the second year.

Admission Requirements

1) Submit a completed application form to the Durham Technical Institute
2) High school diploma or high school equivalency with at least 2 units of higher mathematics (algebra, geometry, or trigonometry) and 2 units of science (biology, chemistry, or physics)
3) Good physical and mental health; a health examination and chest X-ray
4) Institute testing
5) Personal interview



7

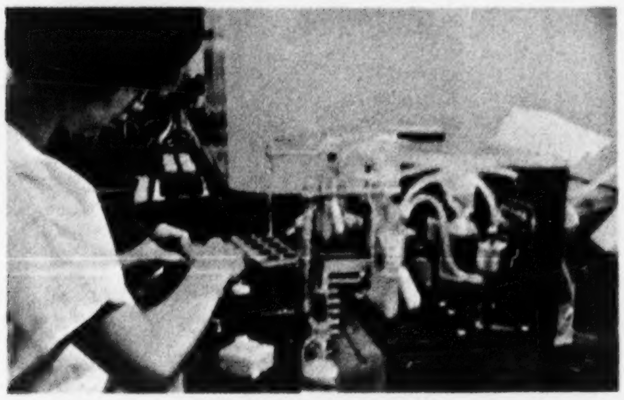
Medical Laboratory Careers

Careers associated with a medical laboratory are numerous, and the educational training necessary for these careers varies. Applicants are usually required to be high school graduates with some course work in the sciences, such as biology and chemistry.

The Duke University Medical Center has limited lab opportunities which are primarily related to general medical laboratory training (on-the-job work as a laboratory trainee). Other lab areas which offer training include histology, cytotechnology, and pathology.

Medical technology is one of the newest and fastest growing professions associated with modern advances in medical science. Medical technologists perform a wide range of complex diagnostic and treatment procedures that help determine the causes and cures of diseases.

A bachelor's degree in medical technology requires four years of study. The natural sciences are emphasized in the first three years of college work. During the final year, students participate in a program at a medical technology (laboratory) school, and then the college awards a baccalaureate degree.



Medical Office Careers—Ward Clerks, Medical Clerks, Medical Secretaries, Medical Transcribers

Employees interested in learning basic secretarial skills related to a medical office may enroll in the ward clerk training program, which is offered through the Duke University Training Center. Two weeks' on-the-job training is required to complete the course. The Training Center also offers a secretarial lab course, a secretarial refresher lab course, and a medical terminology course. (See page 24 for further details.)

At the present time, the Duke University Medical Center's program of study offered to medical transcribers is structured for employees who have had secretarial training. Contact the PEP office for further information.

Nuclear Medicine Program

The Nuclear Medicine Program offers twelve months of instruction and clinical training in the Division of Nuclear Medicine, Department of Radiology. The program is divided into two parts: a three-month didactic and laboratory preclinical course, and a nine-month internship in the clinical aspects of Nuclear Medicine Technology.

Courses cover topics such as nuclear physics and instrumentation, nuclear chemistry, radiation safety, and radiation biology. The clinical internship includes personal instruction and training in blood volume-red cell mass determination, renograms, scanning, research techniques, thyroid function studies, placental localization, and ultrasound techniques.

Applicants with any of the qualifications listed below will be considered for admission.

1) Students who have earned two years or more of college credit toward a degree in any science field
2) Registered or registry-eligible medical technologists
3) Registered or registry-eligible radiologic technologists
4) Registered nurses

Nurse's Assistant—Patient Care Assistant II

A nurse's assistant (PCA II at Duke) maintains orderliness, cleanliness, and safety in the patient's environment. Caring for selected patients as directed and assisting with the general nursing care of patients under supervision are also duties of nurse's assistants. As members of the auxiliary nursing team, they must have a sense of responsibility, respect for small details, and a genuine liking for people.

Training encompasses an eleven-week program of classroom study and clinical practice. The course is given every school quarter at the Durham Technical Institute.

Admission Requirements

1) Submit an application to the Durham Technical Institute
2) Institute testing
3) Personal interview

Operating Room Technician

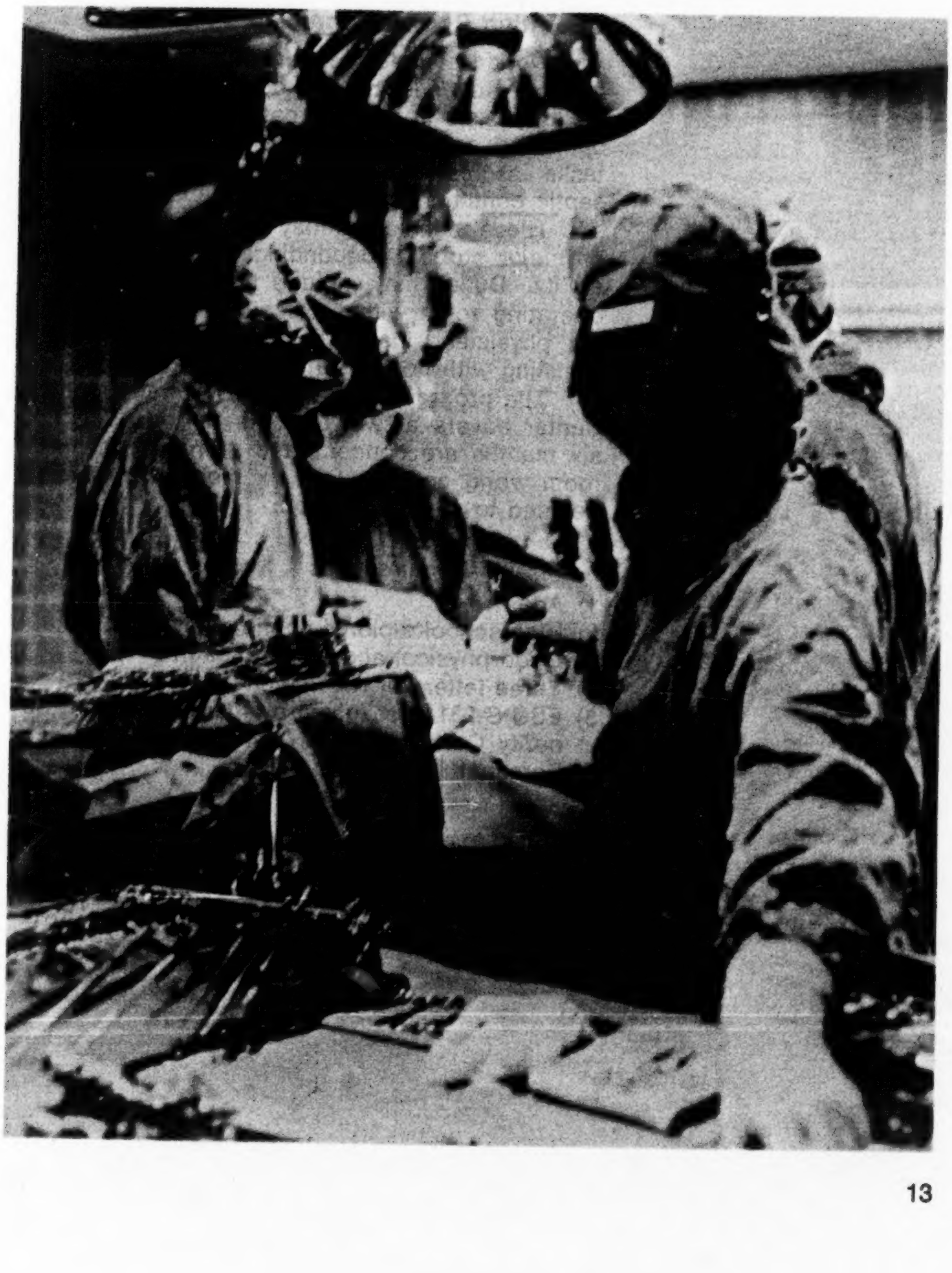
Working under continuous direction and medical supervision, the operating room technician assists in treating patients in the hospital operating and emergency rooms, and performs tasks associated with maintaining maximum antiseptic conditions.

These technicians may assist in either minor or major surgery, depending upon training and ability. Duties may include helping prepare the operating room with surgical instruments, handing physicians instruments during surgery, and assisting with postoperative dressing.

The program at the Duke University Medical Center covers a twelve-month period. The first six months are concentrated primarily on classroom work, and the last six months are mainly devoted to clinical rotation.

Admission Requirements

1) Ages 18-35
2) High school diploma or the equivalent
3) Good physical and mental health
4) Three letters of recommendation
5) ESC S-231 Test (given by the Employment Security Commission)
6) Personal interview



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Pathology Assistant Training Program

The pathology assistant program is designed to meet the growing need for trained personnel in the field of pathology, and will provide a unique training opportunity for a small number of selected students.

Training covers a one- to two-year period; the length of the program will depend upon an individual's past education, experience, and progress. The first six months are devoted to instructional classroom and laboratory work; the remainder of the course, to practical experience in the Department of Pathology and various allied departments.

Students must have one of the qualifications listed below to be selected:

—Graduate (or equivalent) of a four-year accredited college
—Graduate (or equivalent) of a junior college with academic studies
—High school graduate with at least two years' experience as a hospital corpsman

Admission Requirements

1) Application with recent photograph
2) Official high school or college transcript
3) Three letters of recommendation
4) A personal interview is encouraged

Patient Care Assistant III and IV

Maintaining orderliness, cleanliness, and safety in the patient's environment are the routine responsibilities of a patient care assistant (PCA) III. As a part of the patient care team, the PCA III should have a thorough knowledge of the work activities and procedures related to patient care for which they are responsible.

Duke University Medical Center trains the PCA III's in the hospital. This on-the-job training takes six months, and the program begins every six months according to the demand. Interested employees need at least two years of successful employment in a hospital or health facility, with three to six of those months at Duke, performing functions and responsibilities related to those of the PCA II. A high school education is desired but not a requirement.

Employees classified as PCA IV's are responsible for direct care of selected patients and on-the-job training of a specialized nature. This job category may consist of special assignments which apply only to specific patient care areas and which require special ability and highly developed skills.

The Medical Center trains PCA IV's in a six-week program. Trainees need a high school diploma with special courses related to biological and social sciences, plus an examination and demonstration of required skills. To be eligible for the program, employees must have worked for three years performing duties similar to those of a PCA III, including one year of employment at Duke's Medical Center.

Physical Therapy

Structured as an A.M. degree program at Duke, the study of physical therapy encompasses two academic years and a summer practicum.

This graduate program gives students a broad foundation in the science of physical therapy as well as the development of skills in administration and supervision, curriculum development and direct teaching, and in advanced clinical education or research.

Admission Requirements

1) Baccalaureate degree
    a) 32 semester hours of laboratory courses in the natural sciences, with a minimum of one academic year of chemistry—including inorganic chemistry—and physics
    b) 15 semester hours in the social sciences, 6 of which must be in psychology
    c) 6 semester hours in mathematics
2) Graduate Record Examination
3) A personal interview is encouraged

Physician's Assistant

As a member of the health team, the physician's assistant works under the direction of the physician in order to assist him in clinical and research endeavors. The physician's assistant is trained to perform certain defined tasks which have traditionally been assumed by the physician.

The educational curriculum for the training of physician's assistants covers a period of twenty-four months and includes a preclinical section and a clinical section of hospital rotation.

Admission Requirements

1) High school diploma or high school equivalency, with some science courses
2) Previous experience in the health field, with at least one year involving direct patient contact
3) Three references
4) Scholastic Aptitude Test and the Math Achievement Test Level I of the College Entrance Examination Board
5) Application files must be completed by April 15 of the year for which admission is requested. To be considered complete, files must contain the following:
   a) a completed application form, including a photograph
   b) transcript records from high school, college, military schools, and all other institutions of academic training

Practical Nurse Education

Individuals enrolled in practical nursing education are prepared to share in the direct care of patients under the supervision of a registered nurse or physician. Throughout the one-year program, students acquire the knowledge and understanding of procedures related to nursing and to biological and social sciences. Skills in nursing practice, communications, and interpersonal relations, and the use of sound judgment are developed.

Graduates of the program are eligible to take the licensing examinations given by the North Carolina Board of Nursing.

Admission Requirements

1) Submit an application to the Durham Technical Institute
2) Institute testing
3) Personal interviews
4) Health and dental examination

Registered Nursing—Diploma Program

This three-year diploma program in nursing gives students preparation in basic scientific principles which are used in giving nursing care and in recognizing indications of diseases, disabilities, and the needs of patients. Registered nurses are qualified to organize and implement a nursing plan that will meet the immediate needs of patients; and with associated health personnel, they may plan for the care of patients. In addition, they may be responsible for directing other members of the nursing team.

R.N. diploma programs offered in this area are at Watts Hospital in Durham, and Rex Hospital in Raleigh. Admission requirements are similar, but each school should be contacted for detailed information.

Admission Requirements

1) High school graduate (with 2 units in algebra, 2 units in a foreign language, 2 units in the natural sciences, and 2 units in the social sciences)
2) Good physical and mental health
3) Personal interview
4) Scholastic Aptitude Test of the College Entrance Examination Board (SAT)

X-ray Technology Certificate Program

The X-ray Technology Certificate Program at the Duke University Medical Center is a two-year course of study beginning in September. X-ray technicians (radiological technologists) are trained to take radiographs of bones and organs for diagnostic purposes and to use radiation as a therapy and treatment for some diseases.

Under the supervision of radiology residents, radiological technologists, and hospital faculty, X-ray technologists are trained in the skills necessary for operating X-ray apparatus.

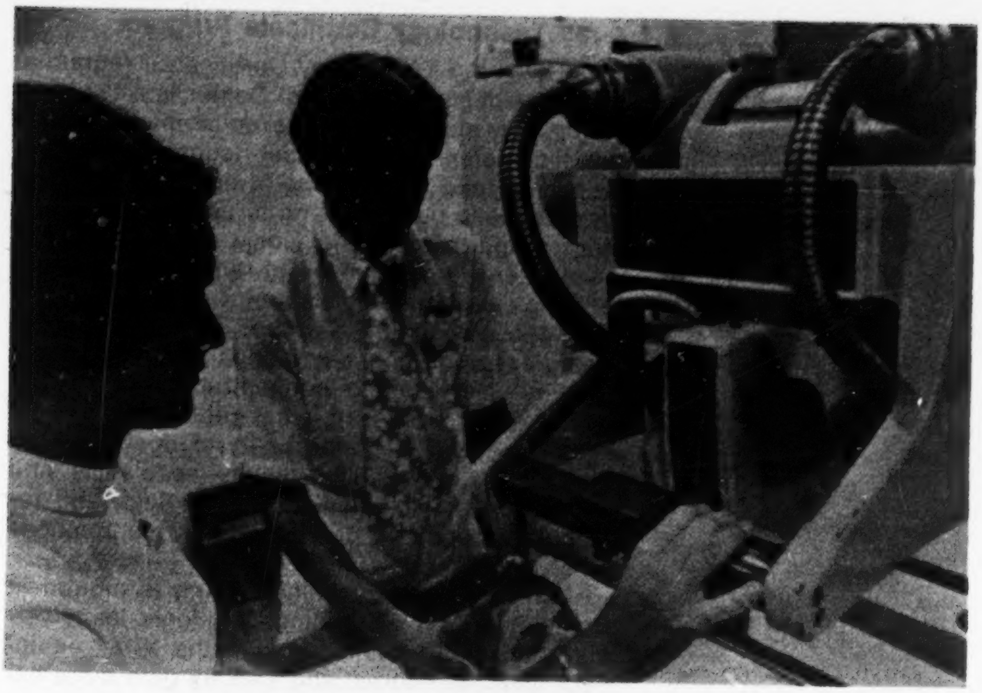
First-year students concentrate on classroom studies and, at the same time, get general clinical experience and the opportunity to operate X-ray equipment. In addition, faculty specialists and guest speakers in the field of radiology and radiologic technology present weekly conferences for students.

More clinical specialty training is offered in the second year of training. Students learn various advanced techniques with the X-ray equipment and procedures; and as they gain more experience, they are given more clinically-related responsibility.

Admission Requirements

1) Contact the X-ray Department and complete their application
2) High school graduate (ranking in upper third of graduating class); and, preferably, some college experience
3) Three references
4) Personal interview

Application deadline is July 15.



DUKE UNIVERSITY TRAINING CENTER

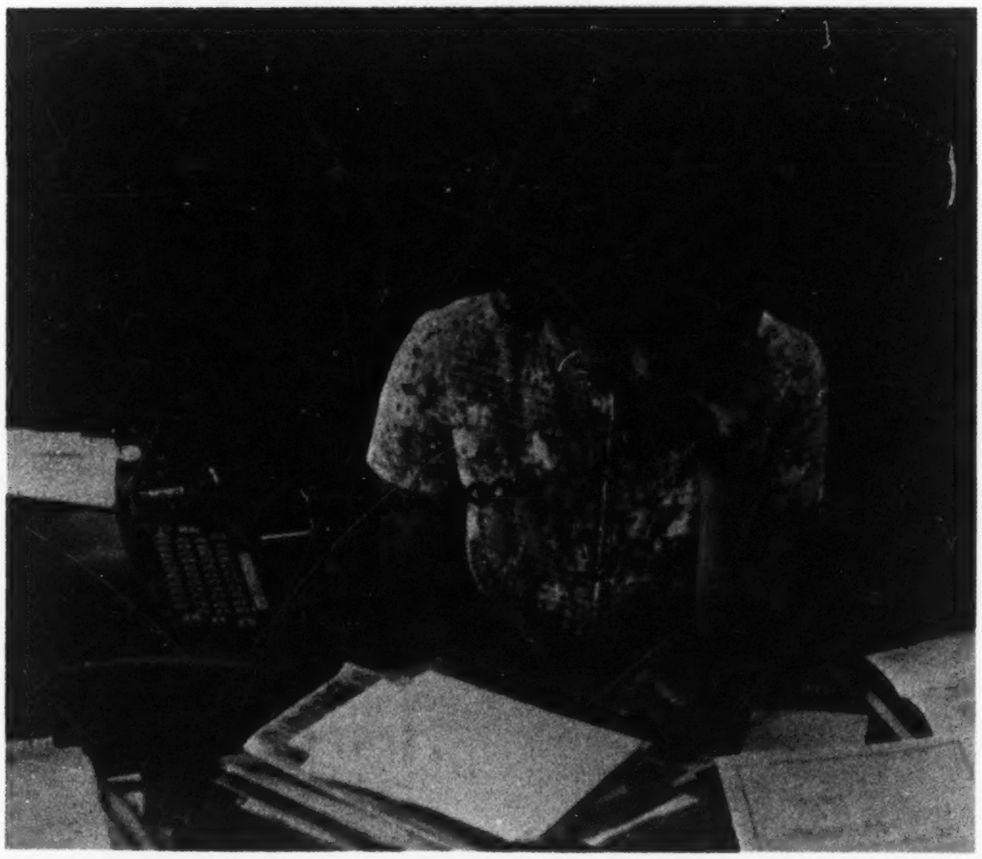
Duke University recognizes the need of its employees to share in its commitment to educational advancement. Thus, the Employee Training and Development Center has been established to provide employees the opportunity to develop careers and to grow personally through their achievements.

The training and development program is designed to help Duke University personnel increase their work-related skills and supervisory ability as well as to provide for management development and personal enrichment. All Duke employees are eligible for admission, and there is no tuition charge for the courses.

Under provisions of the Fair Labor Standards Act, nonexempt employees are paid their regular rate while attending job-related training classes. Attendance at courses is not counted as working time if (1) attendance is at a time outside the employee's regular working hours, (2) attendance is voluntary, (3) the course is not directly related to the employee's job, and (4) the employee does not perform any productive work during attendance.

High School Diploma Program

In cooperation with the Durham Technical Institute, the Training and Development Center has set up an individual study laboratory where employees, in their spare time, can work toward a high school diploma or the equivalent. Set up on an individual basis, the program evaluates and makes provisions for each person's needs.



Secretarial Skills Program

With increasing demand for competent secretarial help, the Center offers the following courses to help employees develop and advance skills in this area.

Secretarial Lab. Through programmed instruction, this course is designed to cover the basic skills necessary for today's secretary (typing, steno). No particular background is necessary to enroll in this course, but the student must demonstrate an aptitude for clerical work.

Secretarial Refresher Lab. This course is aimed at secretaries who want to learn and/or improve the skills necessary for their profession. Subjects covered by the course are typing, steno, and office practices, including grammar, letter writing, and work organization. Those who choose to enroll in this course must indicate their area of concentration at the time of registration.

The courses mentioned above are the most widely-used of those offered by the Training Center, but there are, of course, other courses available to employees. The Center works closely with the PEP Program to develop and conduct any course for which there is sufficient employee interest.

For further information about the programs of instruction available through the Training and Development Center, contact the PEP office.

Dr. Anlyan. There are, in conclusion, Mr. Chairman, some searching long-range questions that we should raise for the record as to whether the current legislation might be a series of stopgap measures. We do not think so. We feel it is an immense step forward in broadening our educational capabilities of academic medical centers. But one key issue that has to be faced, sooner or later, is going to be, what sort of a system would the VA fit into, if we should get some form of university health insurance. These questions are under discussion between the outstanding staff of Dr. Musser and the Association of American Medical Colleges liaison committee.

Thank you, Mr. Chairman.

Senator Cranston. Thank you.

Needless to say, I am delighted that out of your great experience and with your high qualifications, you are as positive as you are about this legislation.

Do you have any comment on what has transpired thus far this morning?

Dr. Anlyan. I think, in your questions and answers and Dr. Lee's comments, everything has been adequately covered, Mr. Chairman.

Senator Cranston. Thank you both.

(The prepared statement of Dr. William G. Anylan follows:)

STATEMENT OF DR. WILLIAM G. ANLYAN, CHAIRMAN OF THE EXECUTIVE COUNCIL, ASSOCIATION OF AMERICAN MEDICAL COLLEGES ON VETERANS ADMINISTRATION MEDICAL PROGRAM

Mr. Chairman and members of the subcommittee: The Association of American Medical Colleges welcomes this opportunity to appear before the subcommittee during its consideration of legislation dealing with the medical programs of the Veterans Administration, including assistance to medical schools.

The Association is that national organization of institutions engaged in the formal education of M.D.s either at the undergraduate or graduate levels. It is comprised of all of the 102 medical schools in operation in the United States, more than 400 of the major teaching hospitals, and 47 academic societies which encompass the teaching and research faculties of academic health centers. The Association was formed in 1876 and has been an important force in the evolution of medical education over the intervening years.

The constituent institutions and organizations of the Association are concerned not only with medical education, but also with the training of large numbers of individuals in the related health professions and occupations; as well as with a substantial portion of the medical and health-related research effort of the nation. These institutions also contribute in a critical and indispensable way to the improvement of community health services and to the direct provision of medical and health care to large numbers of American citizens. Thus, the Association and its membership have a deep and direct involvement in the entire scope of health care and health manpower for the nation.

BACKGROUND OF THE VETERANS ADMINISTRATION MEDICAL SCHOOL RELATIONSHIP

Since the end of World War II, U.S. medical schools have enjoyed a mutually beneficial set of relationships with Veterans Administration hospitals. The quality of medical education has been enhanced, and the schools have been able to expand their activities and to increase significantly the number of physicians graduated. In addition, the quality of medicine practiced in the VA hospitals has been improved substantially.

At present, the Department of Medicine and Surgery of the VA maintains an active and close affiliation with 81 medical schools, 51 dental schools, 287 schools of nursing and approximately 400 universities, colleges, and junior colleges training health manpower. Some 93 of the 166 VA hospitals serve as sites for the clinical training of medical students. A tabulation for the 1969–70 academic year indicated that VA hospitals provided some training to more than 11,000, or 31 percent, of the nation's medical students.

The involvement of the Veterans Administration in the physician education effort was a natural outgrowth of its responsibilities in providing for the health care of a defined population—the nation's veterans. It is clear that affiliation of VA hospitals with medical schools substantially enhanced their capabilities for accomplishing this. Affiliation proved effective in facilitating the recruitment of highly competent staff. It provided the environment in which the fruits of the search for new biomedical knowledge could be translated rapidly into improved care. It helped in providing the concentration of resources which has permitted the most sophisticated care available. It was responsible for a graduate training capability within the VA system, enabling the system to assist in meeting its own health manpower needs.

Early in the VA-medical school relationship, the need for close interrelationships and cooperation between the various institutions providing health care in an academic health center was not so critical as it has become today. The reason was that highly sophisticated tertiary medical care had not been developed to any significant degree. Largely secondary care was involved, and there was little incentive to maximize the use of health manpower, equipment and facilities. Now, however, a new element has been added, with the development and expansion of tertiary care. Such activities as open-heart surgery and kidney transplants demand highly specialized health manpower, equipment and facilities, which, in turn, require optimal use within a community. The affiliated VA hospital and the hospital of the academic health center no longer can be operated as totally independent units. All of the resources available must be integrated into an overall, comprehensive program of health care. "Sharing arrangements" now developing, and already in effect, must be expanded. Ideally, the nation's health professions schools and the Veterans Administration—with the largest health care system in the country—should be working in a mutually supportive and interdependent framework to meet the health care needs of all Americans, including our veterans.

The Troubled Relationship

At the same time, Mr. Chairman, the Association must acknowledge a number of overriding problems which are threatening the traditional relationship.

Overcrowding, chronic understaffing, deteriorating physical facilities and increasingly obsolescent equipment compromise the effectiveness and strength of the VA-medical school association. The overriding problem is inadequate financial undergirding of VA medical activities. Inadequate funding has become the dominant problem, principally through the actions of the White House and its Office of Management and Budget. Congress has repeatedly provided increased appropriations for the medical care activities of the Veterans Administration. And repeatedly the Office of Management and Budget has blocked the intent of Congress.

VA hospitals are in a period of crisis. The most highly visible elements of the crisis—overcrowding and understaffing—have been thoroughly aired in the nation's news media and documented by other witnesses in Congressional hearings. There can be but little question that these conditions of crisis adversely affect the quality of medical care rendered to our veterans. What is perhaps not so obvious is that these same conditions of chronic overcrowding and understaffing can also adversely affect the quality of medical education carried out in VA hospitals affiliated with medical schools. The educational experience of undergraduate medical students, interns and residents is seriously affected by VA hospital staff shortages. Furthermore, the restrictions imposed on the orderly growth of the capacity of the VA to care for patients are not responsive to the national need for increasing the number of health professionals educated.

Another serious element of the VA hospital crisis involves deteriorating physical facilities. Many of the existing VA hospitals were opened shortly after World War II. We are now facing the situation that these facilities are from 20 to 25 years old. Many of them lack adequate facilities for medical teaching and research. Furthermore, the rapid pace of medical technology has rendered some of the facilities increasingly obsolescent and has limited their ability to provide effective patient care and a proper educational environment. In some cases, modernization of existing facilities will be sufficient. In other cases, completely new facilities are required—either to meet shifts in national population or to provide adequate physical facilities for the complex equipment and technology associated with today's tertiary care.

The Association suggests that effective steps to correct these critical problems should have the highest priority. In fact, it would consider such action a prerequisite to virtually any broadening of Veterans Administration activities.

Recent Congressional action to increase appropriations for VA medical programs is a hopeful sign. The Association is grateful for such a measure of commitment.

VETERANS' ADMINISTRATION MEDICAL SCHOOL ASSISTANCE

The Association is aware of the many mutual benefits resulting from the affiliation of certain medical schools with Veterans Administration hospitals. The Association applauds the principle that this VA-medical school relationship should be encouraged and enhanced so that as a nation we are better equipped to meet the twin problems of providing the best possible medical care to our citizens and of producing significant numbers of highly skilled physicians to deliver the care. To help meet these problems, the Association has adopted twin goals of increasing the first-year medical school enrollment from 11,360 in 1970–71 to at least 15,000 by 1976, and of establishing 12 new schools by 1976. It is the Association's hope that achievement of these goals can be giant steps toward improving health care for all Americans, including our veterans.

Alternate Legislative Approaches

Achievement of these goals clearly is a major objective also of the variety of legislative approaches pending before the subcommittee to provide special VA assistance to medical schools. The alternate legislative approaches include:

The Veterans Administration Health Manpower Training Act of 1971 (S. 2219), introduced by the distinguished chairman of this subcommittee, and cosponsored by a number of other members of this committee or members of the appropriate committee which considers general health legislation.

The Veterans Administration Medical School Assistance and Health Service Personnel Education and Training Act of 1971 (HJRes 748), introduced by the chairman of the Veterans' Affairs Committee of the other body and overwhelmingly passed recently by the members of that body.

SJRes 76, introduced by Senator Bentsen and the Majority Leader, Senator Mansfield; a joint resolution amending title 38 of the United States Code to authorize the Administrator of Veterans' Affairs to provide certain assistance in the establishment of new state medical schools and the improvement of existing medical schools affiliated with the Veterans Administration.

Each of these bills appears to reflect a basically similar approach, namely, to facilitate the use of VA facilities in expanding medical education, and to provide grants for faculty salaries in new schools and for the expansion of existing affiliated schools. The Association sees a number of important problems in this approach.

First, the Association is concerned about the appropriate geographic location of new medical schools. It is the sense of the Association that new schools should be located for maximum benefit to the health care of the nation, in accord with a nationally planned construction program as proposed by the prestigious Carnegie Commission on Higher Education. The Association is uncertain as to how the fortuitous distribution of presently unaffiliated VA facilities would harmonize with such a national plan. While it is difficult to assess the questions likely to be raised about the kind of VA facilities available for conversion to school use, it would seem likely, at least, that they would not be large and well utilized, but, rather, smaller, remotely located and poorly utilized. It is useful to remember in this context that more than one-third of VA hospitals are located away from urban areas.

Second, the Association is concerned about maintaining the high quality of medical education in the United States. The current high quality of American medical education is based on a thorough understanding of the basic sciences of medicine. The basic sciences are best taught in an atmosphere of scientific inquiry, centered in a university-based environment. Research is an essential part of the medical educational process. The complex of basic science faculty, graduate students, and research laboratories will be extremely difficult to recruit for, and to transplant to VA hospitals lacking either academic affiliations or reasonable proximity of academic medical centers.

Third, the Association is concerned about maintaining the integrity of the agency which currently is charged with accreditation of medical schools in the United States—the Liaison Committee on Medical Education of the American Medical Association and the Association of American Medical Colleges. It is essential that new schools established with VA assistance meet appropriate standards of accreditation. It is equally essential to protect a presently accredited school from expanding so extensively, with VA assistance, that it overreaches its academic resources and jeopardizes its accreditation.

Fourth, the Association is concerned about the fragmentation of responsibility for federal medical educational policy. Prime federal responsibility for assistance to medical education currently is assigned to the Department of Health, Education and Welfare. It would appear inappropriate and imprudent to divide the responsibility among additional federal agencies. Such action would impair national planning for medical education. Divided responsibility between the VA and the DHEW would seem to entangle the schools in a web of potentially conflicting and possibly contradictory regulations and objectives.

AAMC Position

The Association of American Medical Colleges has carefully reviewed the alternate legislative proposals pending before the subcommittee. It is the considered opinion of the Association that enactment of the Veterans Administration Health Manpower Training Act of 1971 (S 2219) could provide a valuable supplementary source of federal assistance to important segments of the nation's health professions educational system, provided careful attention is given to the considerations noted above.

A comparison of the three legislative proposals for their approaches to assisting establishment of new schools and expansion of existing affiliated schools shows the following:

The Veterans Administration Health Manpower Training Act of 1971—

(1) provides maximum coordination between the VA and the DHEW, not only at the Secretary-Administrator level but also at the advisory group level through authorization of an appropriate subcommittee of the Special Medical Advisory Group;

(2) provides maximum flexibility in funding the two assistance programs and the most realistic levels of funding;

(3) imaginatively broadens the two programs to include assistance to area health education centers, a concept suggested by the Carnegie Commission; and

(4) includes essential assurances that any new school assisted through the program would meet apropriate accreditation standards and that any existing school would not expand its operations to the jeopardy of its accreditation.

In addition, S 2219 provides special authority for funds to remodel and make special allocations to VA hospitals for health manpower education and training; requires construction of new VA hospitals for close proximity to affiliated medical schools, requiring the new hospitals to include appropriate education facilities; and broadens the health manpower education and training mission of the VA's Department of Medicine and Surgery.

The Association of American Medical Colleges finds these provisions to be particularly attractive. If enacted and fully funded, the Veterans Administration Health Manpower Training Act of 1971 could serve as an important first step in correcting some of critical problems threatening the traditional VA-medical school association.

VETERANS ADMINISTRATION MEDICAL CARE

The medical care programs of the Veterans Administration obviously enjoy an important role in health professions education. However, for a number of reasons, serious limitations curtail the full potential of the role.

The patient population of Veterans Administration facilities is excessively narrow and limited in scope compared to the needs of a balanced medical education program. Almost all VA patients are males, and many in the older age groups suffer from chronic illnesses. Even though Vietnam veterans comprise some 14 percent of the VA's workload, the average age of all VA patients is slightly more than 50 years. The medical problems encountered by such an adult male population do not encompass the full range of significant medical problems with which the student of medicine should be familiar. Thus the resources of the Veterans Administration must be substantially augmented by other clinical faciities.

Furthermore, the concepts of comprehensive care and ambulatory medicine are becoming increasingly important in health care delivery. Medical schools already have adopted these concepts in their educational programs. Modern medical education emphasizes comprehensive medical care and places increasing emphasis on teaching medicine in an ambulatory setting, as well as in the hospital. The university-based academic health center has the flexibility to respond to this new concept of health care. The VA health care system, because of certain legislative limitations in the extent to which ambulatory services can be provided, does not have such flexibility and immediate responsiveness.

As matters now stand, the VA medical program is ill-suited to participate in this important new approach in medical education programs. The Association recognizes that the VA has introduced programs relating to pre- and post-hospital care. It acknowledges that these are constructive, first-step programs, but they do not provide sufficient scope within which medical care under the best modern concepts can be rendered. Thus VA hospitals are progressively more limited in the extent to which they can contribute to the education of the nation's physicians.

Alternate Legislative Approaches

Broadening the coverage of VA medical care and improving professional career opportunities in the Department of Medicine and Surgery appear to be the overriding goals of the pending VA medical program legislation. The bills include:

> The Veterans Medical Care Act of 1971 (S. 1924), an Administration-supported bill to provide improved medical care to veterans, and to improve recruitment and retention of career personnel in the Department of Medicine and Surgery.
>
> The Veterans' Health Care Reform Act of 1971 (S. 2354), introduced by the distinguished chairman of this subcommittee to provide improved and expanded medical care and nursing home care to veterans, to provide hospital and medical care to certain dependents and survivors of veterans, to provide for improved structural safety of VA facilities, to improve recruitment and retention of career personnel in the Department of Medicine and Surgery, and for other purposes.
>
> The Veterans' Administration Continuing Medical Education Act (S. 2355), introduced by the subcommittee chairman to afford advanced residency-type training to personnel of the VA and other federal departments and agencies at regional medical centers established at VA hospitals throughout the United States.

The imbalance in the patient population of VA facilities has long been recognized as one of the factors inhibiting the utility of VA facilities in the clinical education of medical students. As the Carnegie Commission has pointed out in discussing the role of the VA in the development of area health education centers: ". . . the Commission does not believe VA hospitals would be appropriate as nuclei for area health education centers unless their policies were changed to permit the admission of patients of all types instead of veterans only."

AAMC Position

The Association of American Medical Colleges can comment on these legislative proposals only to the extent to which they deal with medical education.

The Association is encouraged by the steps proposed in both S. 1924 and S. 2354 to improve the balance in the patient population of VA facilities, to expand the provision of ambulatory care, to improve the development of new health care services and to encourage expansion of sharing arrangements. Each of these proposed steps would help to increase the mutual, educational-patient care benefits of the VA-medical school relationship.

The Association is compelled to note, however, that each of these same proposed steps opens searching, fundamental questions about an appropriate future role for the VA medical program in health care delivery. The questions raise important issues. And the issues are being explored in the VA–AAMC Liaison Committee.

The Association also is encouraged by the recognition that S. 2355 gives to the importance of continuing medical education. Establishment of regional centers for continuing medical education, as proposed in S. 2355, would provide a useful supplement to the efforts of the nation's medical schools in the critical field of continuing education.

Senator CRANSTON. The next witness is Col. Herbert M. Houston, chairman and legislative director, World War I Veterans Legislative Committee.

I welcome you. I appreciate your presence, and could you help expedite the proceedings, too, because of this important conference?

STATEMENT OF COL. HERBERT M. HOUSTON, CHAIRMAN AND LEGISLATIVE DIRECTOR, WORLD WAR I VETERANS LEGISLATIVE COMMITTEE; ACCOMPANIED BY FLOYD HENDERSON, NATIONAL ADJUTANT, AND J. B. KOCH, NATIONAL COMMANDER OF VETERANS OF WORLD WAR I, U.S.A., INC.

Mr. KOCH. If I may, I would like to introduce the people with me: national legislative director, Colonel Houston, from Tennessee, and our national adjutant, Floyd Henderson, from North Dakota.

I am J. B. Koch, national commander of Veterans of World War I, U.S.A.

I speak in behalf of veterans of World War I, concerning S. 2219, S. 2354, and S. 2355 and House Joint Resolution 748, which I understand is being considered by this distinguished subcommittee. We have one common objective, namely, a quick contribution to medical manpower needs confronting the country today. This is publicized daily in the press advertising medium, TV, and radio, and more forcefully manifested when illness effects one's household.

We are told there is an estimated shortage of 48,000 physicians, 17,800 dentists, 150,000 nurses, 266,000 allied health and other personnel. At a time when great concern is being expressed about the high cost of medical care, it would appear that the fact that the Veterans' Administration is providing quality care at about one-third the cost of other medical systems is being ignored. At a time when concern is being expressed about the shortage of medical personnel, it would appear that the vast educational program of the Veterans' Administration is ignored.

Currently, the Veterans' Administration has 166 hospitals, 202 clinics, 63 nursing homes, 16 domiciliaries and some 150,000 physicians, nurses and other personnel providing health services to approximately 6 million of the 28 million veterans. The Veterans of World War I, represent 8 percent of the veterans population while at the same time, 30 percent of the patient load in Veterans' Administration hospitals are Veterans of World War I. It is our judgment that virtually all Veterans' Administration hospitals have at least the same quality as any other good community hospital. And many of these hospitals serve as medical school teaching hospitals and are comparable to the best university hospitals. There is no other system in the United States, nor for that matter, in the entire world, which is centrally administered, which is involved in the education of some 11,000 medical students and 5,000 interns and residents each year.

The Veterans' Administration has recently inaugurated a new employment category for physicians' assistants and a number of individuals are now being trained for this position and are actually working in the Veterans' Administration hospitals.

The Veterans' Administration is uniquely qualified to participate in establishment of new medical schools for it is currently affiliated with 80 medical schools, 51 dental schools, 287 nursing schools, 274 university and colleges, and 84 community and junior colleges. During the current fiscal year, 500,000 students will participate in more than 60 categories of training in our institutions. The general public does not realize what a tremendous contribution the Veterans' Administration's medicine has made to the general welfare. In our opinion, Mr.

Chairman, this affiliation is necessary to establish quality personnel. The fact that tuberculosis is no longer the scourge which it once was is due to treatments which originated and were practiced on a massive scale in Veterans' Administration hospitals. The pacemaker, which has saved many lives in thousands of heart patients, had much of its basic research performed there in Veterans' Administration hospitals. A research physician in the Bronx Veterans' Administration hospital was the first individual to isolate a virus which could conquer leukemia. With 28 million veterans in this country, who with their families constitute 40 percent of our population, it is not strange for consideration to be given to better utilization of this great facility, not only to improve the care of veterans, but to make a greater medical contribution.

House Joint Resolution 748, calls for a pilot program which would permit the administration of the VA to enter into agreements with not more than five States, geographically dispersed, to assist in the establishing of five new "remote areas" facilities in areas away from big cities of our country and the establishment of comparatively small medical schools but those will be fully accredited and staffed with the highest personnel. In addition to this planning, there is provision for the training of additional paramedical personnel below the professional standard of doctors, nurses, and dentists which would not only increase the ratio of staff to patients in Veterans' Administration hospitals and university hospitals, but provide a large reservoir of trained personnel for the hospitals across the Nation. If this program were established and the work carried out there is no reason not to expect that it would have a dramatic effect in reducing the great shortage of doctors, nurses, and other personnel which this country so badly needs if it is fully implemented. There are a number of achievements one would expect of this proposal:

(1) Better care for a veteran of this country;

(2) To improve training facilities faster for doctors, dentists, nurses, and medical personnel by placing and training all on a higher level and provide training for those who do not have the opportunity today, and;

(3) It would provide a greater supply for personnel, not only for the Veterans' Administration, but for all hospitals in the country.

S. 2219 has similar general purposes as House Joint Resolution 748 and would, in our opinion enable the Congress to determine where appropriated funds were to be used.

With the increasing population in our country calling for an accelerated increase in medical professionals, the provisions of S. 2219 to provide training for physicians' assistants, dentists' assistants, and nurse practitioners, would appear to us as a long overdue attempt to correct the situation in health care. It appears to us that the value of the paramedic has been proven on the battlefields of Vietnam. Those trained under the supervision of physicians in health care, ease the strain on physicians and nurses enabling them to better meet the needs in hospitals, health centers, and nursing homes.

As you must know Mr. Chairman, our primary concern is for the veteran, it does not stop there however, for we are concerned about the families of veterans and others who are not eligible for veterans' hospitals.

The Veterans of World War I are concerned about the strengthening of the Veterans' Administration hospital program, and the Veterans' Administration in general. And we are opposed to the apparent retrenchment proposed by the Office of Management and Budget. S. 2354 would provide health care for many of our group of veterans.

The Veterans of World War I have long felt the need for outpatient care for nonservice-connected veterans, as well as in-hospital care. Without further elaboration, we strongly urge the passage of S. 2354.

S. 2355, it would appear Mr. Chairman, would be a directive to the Veterans' Administration to accomplish what has been authorized by prior legislation with some new stipulations.

Mr. Chairman, the veterans of World War I are deeply concerned because of their advancing age, and the increasing cost of hospitalization and medicine and whereas the number of patients in the Veterans' Administration hospitals now constitute 30 percent of their patients of World War I veterans. The future hospitalization and care of the patient look gloomy unless medical manpower is increased.

I want to thank you, Mr. Chairman, for the privilege of appearing before you on behalf of this important question which we believe is a step in the right direction.

Thank you, sir.

Senator CRANSTON. Thank you very much Colonel. Your presentation and your testimony is most helpful, and it is particularly significant to have your strong support for the best possible relationship in terms of affiliation between the veterans hospitals and medical schools, which is an important part of this program, as you know.

We will do all we can, I assure you, to help the veterans of World War I, who need assistance.

As you know, we were successful last year in gaining enactment of an amendment I authored on the Senate floor to provide hospital care for any veteran over 65. And we will take whatever steps are appropriate to continue to help our older veterans.

In your testimony, you referred primarily to House Joint Resolution 748. I would appreciate it if you would submit for the record your comments on S. 2219 and S. 2354 and 2355. That would be helpful to us.

Colonel HOUSTON. Mr. Chairman, may I apologize for errors in this printed text. We will correct these.

Senator CRANSTON. That will be very helpful. Thank you very much.

(The prepared statement of Mr. Koch follows:)

STATEMENT OF J. B. KOCH, NATIONAL COMMANDER, VETERANS OF WORLD WAR I, U.S.A., INC.

Mr. Chairman and Members of The Committee, I am J. B. Koch, National Commander of Veterans of World War I of the U.S.A., Inc., speaking in behalf of Veterans of World War I concerning S. 2219, S. 2354, S. 2355 and H.J. Res. 748, which I understand is being considered by this distinguished Sub-Committee, have one common objective. Namely, a quick contribution to the medical manpower needs confronting the country today. This shortage is publicized daily in the press, advertising medium, T.V. and radio and more forcefully manifest when illness affects one's household.

We are told there is an estimated shortage of 48,000 thousand physicians, 17,800 dentists, 150,000 nurses, 266,000 allied health and other personnel.

At a time when great concern is being expressed about the high cost of medical care, it would appear that the fact that the Veterans Administration is providing quality care at about one-third the cost of other medical systems is being ignored. At a time when concern is being expressed about the shortage of medical personnel, it would appear that the vast educational program of the Veterans Administration is ignored. Currently the Veterans Administration has 166 hospitals, 202 clinics, 63 nursing homes, 16 domiciliary and some 150,000 physicians, nurses and other personnel providing health service to approximately 6 million of the 28 million war veterans. The Veterans of World War I represent 8% of this veterans population while at the same time, 30% of the patient load in Veterans Administration hospital are Veterans of World War I. It is our judgment that virtually all Veterans Administration hospitals are at least the same quality as any good community hospital and many of these hospitals serve as medical school teaching hospitals and are comparable to the best university hospitals.

There is no other system in the United States nor for that matter in the entire world, which is centrally administered which is involved in the education of some 11,000 medical students and 5,000 interns and residents each year.

Veterans Administration has recently inaugurated a new employment category for physicians assistants and a number of individuals are now being trained for this position and are actually working in the Veterans Administration hospitals.

Veterans Administration is uniquely qualified to participate in the establishment of new medical schools for it is currently affiliated with 80 medical schools, 51 dental schools, 287 nursing schools, 274 university and colleges and 84 community and junior colleges. During the current fiscal year, 500,000 students will participate in more than 60 categories of training in our institutions. The general public does not realize what a tremendous contribution the Veterans Administration medicine has made to the general welfare. In our opinion, Mr. Chairman, this affiliation is necessary to maintain the quality personnel. The fact that T.B. is no longer the scourge which it once was is due to the treatments which originated and were practiced on a massive scale in Veterans Administration hospitals. The pacemaker which has saved the lives of thousands of heart patients had much of its basic research performed thereon in Veterans Administration hospitals. A research physician in the Bronx Veterans Administration hospital was the first individual to isolate a virus which could conquer leukemia. With 28 million veterans in this country, who with their families constitute 40% of our population it is not strange for consideration to be given to better utilization of this great facility not only to improve the care of veterans but to make a greater medical contribution.

H.J. Resolution 748 calls for a pilot program which would permit the administration of the V.A. to enter into agreements with not more than 5 states, geographically dispersed, to assist in the establishing of 5 new "remote areas" facilities in areas away from big cities of our country and the establishment of comparatively small medical schools but those will be fully accredited and staffed with the highest personnel. In addition to this planning, providing for the training of paramedical personnel below the professional standard of doctors, nurses and dentists which would not only increase the ratio of staff to patients in Veterans Administration hospitals and university hospitals across the nation. If this program were established and the work carried out there is no reason not to expect that it would have a dramatic effect in reducing the great shortage of doctors, nurses and other personnel which this country so badly needs if it is fully implemented. There are a number of achievements one would expect of this proposal, 1, better care for a veteran of this country, 2, to improve training facilities faster for doctors, dentists, nurses and medical personnel by placing and training all on a higher level and provide training for those who do not have the opportunity today, and 3, it would provide a greater supply for personnel not only for the Veterans Administration but for all hospitals in the country.

Mr. Chairman, the Veterans of World War I are deeply concerned because of their advancing age, and the increasing cost of hospitalization and medicine and whereas the number of patients in the Veterans Administration hospitals now constitute 30% of their patients of World War I Veterans. The future hospitalization and care of the patient load looks gloomy unless medical manpower is increased.

I want to thank you, Mr. Chairman, for the privilege of appearing before you in behalf of this important question which we believe is a step in the right direction.

Senator CRANSTON. Our next witness is Dr. Amos Johnson, past president of the American Academy of Family Practice, Garland, N.C.

STATEMENT OF DR. AMOS JOHNSON OF GARLAND, N.C., PAST PRESIDENT, AMERICAN ACADEMY OF FAMILY PRACTICE

Dr. JOHNSON. Mr. Chairman, I assume you would like for me to be through like 5 minutes ago.

I want to say that I am speaking here today for myself. I have looked over and evaluated the bills. I have been in the private practice of medicine referring people to Veterans' Administration hospitals all over for a period of 37 years, or since the Veterans' Administration hospitals came into being. I have had a long-term view of the whole bit.

The organization for which I usually speak, sometimes the Medical Society of North Carolina, the American Academy of Family Practice, has not had time to review all of this legislation for the purpose of providing testimony here today. I only found out Saturday evening that I was going to be permitted to testify, so I am speaking for myself, but in general for probably 60,000 or 75,000 people who provide health care, as I do, as a family physician or general practitioner.

One thing I want to do is to establish in the history of this legislation in the record the absolute need for changes in the whole system of health care being provided by the Veterans' Administration. I think undoubtedly the restriction of the enabling legislation over the years up to the present time has done much to contain the effectiveness and quality of health care provided by this organization.

Other factors, politically oriented, locating Veterans' Administration hospitals years ago, perhaps in communities and towns far removed from the whole action of health education, health care services, had something to do with it. All of this together has made it up to the present time almost impossible to keep high quality staff, not only medical staff, but nursing and paramedical staff, at many of your veterans' hospitals.

The recent activity in building your newer hospitals around and in conjunction with medical centers and medical schools has done much to improve this situation. Despite what Dr. Anlyan said a few minutes ago as relates to the difference in the sophistication and productivity, excellence of the Veterans' Administration school in Durham, Veterans' Administration hospital in Durham, and the Duke University Medical Center, believe you me, there has been an immense improvement in the quality of service in the Veterans' Administration hospital in Durham over and above the other Veterans' Administration hospitals in North Carolina.

For years I would send all my patients to Fayetteville, N.C., which is a remote place, fairly sizable, does have fairly sizable Veterans' Administration facility, but when I had a veteran years ago who was ill and needed sophisticated care, I would send this person to Duke University or to the University of North Carolina, if I expected the person to do well and to survive.

These people had to pay their own ways. I have done it for a number of years even when they were entitled to go to Fayetteville, the closest

Veterans' Administration hospital. But, sir, it is better to come back from Duke alive and with a defect than to come back from Fayetteville in a hearse, and those were the determining factors about making referrals up to the present time.

I think that your educational and continuing educational proposals in all of these bills are excellent. I do support them all. I think they are particularly important. I think it is important that your Veterans' Administration hospitals be given the opportunity to—and those that are not close to teaching centers—to develop regional educational programs, to participate with community general hospitals, nonprofit hospitals, in resident training programs and in the bit of continuing education, not only for those in the Veterans' Administration or those in the affiliated community general hospital, but a program that would reach out to the general area of referrals, once these hospitals obtain patients.

I have in mind Asheville, N.C., where the University of North Carolina presently is attempting to work or is working with the sizable and good community general hospital.

Now, it would be entirely possible for the Veterans' Administration facilities which you have in Asheville, which are sizable, to work in conjunction with this community general hospital and establish a very excellent regional educational program, a continuing educational program, which would take care of 15 or 20 counties in western North Carolina that have no access to continuing education, and would also reach to three other States, all coming together up in the northwest section of North Carolina.

I think also that I must take a crack at Dr. Anlyan and his folks as we go along. I see their finger in the testimony of all of the health manpower bills. I expected it. It does not surprise me. They are overconcerned about the expansion of the membership of classes in medical schools. The expansion of production of doctors in the medical schools is exceedingly restrictive. It is overrestrictive.

There are many people too concerned about what may happen to the quality of medical education if they expand their educational facilities, their classes, beyond certain very small limits which they would like to stick to. But there are others in medical education who will tell you, who are working in teaching in schools, that if these programs are funded reasonably adequately, that there is no reason why within a period of a very short number of years, 4 to 6 years, that the average medical school could not double its productivity of physicians.

Historically, the medical educators, the Association of American Medical Colleges, has been the vehicle or the organization that has restrained the number of doctors that has been produced in the United States. I find it almost intolerable to see States like yours, California, passing local legislation to permit physicians who trained in Mexico, for example—where the quality of education is considerably lower than that in any medical school in the United States, even with the expansion—I find it almost unacceptable to see us open up and accepting these people to come back into our country, when we could have much more efficiently educated these people with our own programs expanded.

I also cannot sit still and tolerate people who get medical education, underdeveloped education from underdeveloped countries, who come to this country as residents under programs, and so forth, which bring them to this country, and then by some mechanism they elect to stay.

I don't think we can tolerate this. The only way we can do anything about this is to expand our medical education. The Veterans' Administration program for staffing of medical schools, requiring that future medical facilities, hospitals built by Veterans' Administration, must be in conjunction with presently operating medical schools or educational facilities or be built around a proposed new school, I think that is good.

But I think this: That we have to analyze the type of doctors we need in this country. Somebody said probably we need 50,000 more physicians today. I am not sure in my mind if we had 50,000 more physicians today who practiced as the last 50,000 who came out of medical education are practicing today, that it would not disrupt our system.

Medical education today is not adapting its productivity to the realistic needs of this country for physician manpower. To be specific, I think we are producing entirely too many surgeons, and those who live by cutting, sir, can rationalize the need for an operation. I think that we need to go very strongly into looking at the essential needs for manpower in this country.

One other bit and I will stop: The paramedical personnel, the physician's assistant. I had one for 33 years. I had the first one I know of in this country. Duke University's program, which was the pilot program in medical schools to train these people, was adapted after studying my person and having students and faculty visits and work with me in my practice. This is a very practical matter to extend the arms and productivities of physicians by the use of paramedical personnel.

In my office with my group practice, with my team practice, on any given day by virtue of having this trained person and others on the team at a lesser level, I can comfortably take care of 50 percent more of the needs of the people in my community and do it at a price which they can afford.

I realize, Senator Cranston, this has been sort of a garbled and hurried-up presentation, but I will submit my statement for the record.

Thank you for the privilege of coming here.

Senator CRANSTON. It was not at all garbled. Your prepared statement is a very constructive one, and I appreciate having that also for the record. I would appreciate it also if, because of your great experience in training and utilizing physician's assistants and medical technicians, if you will submit for the record any additional material outlining the way you think that concept should work and what you feel the VA might do in that field.

Whatever concepts you have on that would be appreciated. Regarding the Association of American Medical Colleges, I want to point out that while they opposed the original Teague bill, they are now supporting my bill, so there is a clear sign of recognition on their part of the need for advances.

Dr. JOHNSON. I think that it would not be amiss to stimulate them more as we go down the road. I believe this sincerely.

Senator CRANSTON. Perhaps your testimony will stimulate them some.

Dr. JOHNSON. I believe if medical education were supported as medical education and not from the dri-through and skim off and pinch in the corners of medical research, that those who provided the money could take that money and require more productivity of the things needed than they can under the present system of financing medical education.

Senator CRANSTON. How do you react to the concept of providing VA medical care for the families and survivors and dependents of veterans with service-connected disabilities?

Dr. JOHNSON. I think it is essential. You asked Dr. Musser some things about that and some of the others also. I for one have had no hangup about sending veterans to Veterans' Administration hospitals, who had no service-connected disability. I have forced veterans hospitals in my area to take them in by certain techniques that can be done.

The admitting officer is required to record all of the phone conversation when a doctor refers a patient and by a way of putting the onus on this admitting officer if this patient dies, I have been able to get people in who had no service-connected disability and taken care of well. I see no reason why the Veterans' Administration should not expand its services to take care of those people who are dependent on those who have service-connected disabilities which render them unable to take care of these people themselves.

I think that it would be very good for the Veterans' Administration hospitals, if in many instances the staff of the Veterans' Administration hospitals were opened up to local physicians so that they could practice within the confines of the VA hospitals and take care of many of the complaints which the Veterans' Administration hospitals do not have manpower to take care of at the present time.

I would be in support of that.

Senator CRANSTON. Do you support the concept of VA medical programs participating actively in medical education, including medical schools as well as residential training programs and continuing education programs?

Dr. JOHNSON. Yes, sir; I would support the medical schools concept per se as being in conjunction with other facilities in the area where the school is going to be placed. I would be a little bit hesitant to say that any branch of the Federal Government at this particular moment should have their own medical school to train their own personnel totally independent of all other medical education at the present time.

But I certainly see ample reason for the Veterans' Administration funding of new medical schools in conjunction with the facilities which they have.

Senator CRANSTON. Briefly, what do you envision as the future position of VA medicine in the future medical and health care effort of our National Health care program?

Dr. JOHNSON. I envision ultimately that all medical care will be provided on a per-capita basis, health care for all the people in this country.

When that time comes and is effective and productive of high quality care, I see the Veterans' Administration being in for those for whom they owe support for health care, buying into these efficient groups and permitting the groups to use the hospital facilities and outpatient facilities.

I think that ultimately if we get to a per-capita payment for health service in this country, the Veterans' Administration will contract for the professional services to be provided in that hospital.

Senator CRANSTON. What are your feelings or thoughts on innovation in medical education? Particularly what do you think about shortening the duration, timewise, of the curriculum?

Dr. JOHNSON. Nobody anyplace has ever satisfactorily correlated chronological passage of time to the learning process. For medical educators to say that of necessity there has to be 4 years of training for a person to become a doctor—I don't think it can be supported. I think that for certain types of physicians this could be easily reduced to 3 years, if not less. And then let what is now the fourth year be the first year of an internship or residency training program.

I think that we could be assured of equally as good health care because family physicians acquire much of their training and expertise from working in the residency programs and working with people. So I think that there is room for considerable experimentation and innovation in the area of alteration of the curriculum of medical schools.

Senator CRANSTON. Thank you very much. You have been most helpful. We appreciate your patience and your visit.

(The prepared statement of Dr. Johnson follows:)

STATEMENT OF DR. AMOS JOHNSON, GARLAND, N.C., PAST PRESIDENT, AMERICAN ACADEMY OF FAMILY PRACTICE

Mr. Chairman and members of the committee, I am Amos Johnson, a family physician—general practitioner—who has provided comprehensive health and medical services continuously for the past thirty-seven years for a rural community of some 4,000 people in eastern North Carolina.

I have been privileged to work as a provider of medical services during a period involving four decades—during which time almost unbelievable scientific medical progress has been made possible largely by tax supported scientific research. It is pleasant and satisfying to reminisce through the progressive stages of this incomparable progress. Concurrently, it is painful and heart rending to think back to the hundreds and thousands of patients, all of them personal friends and acquaintances, who died prematurely for the want of these wonderful scientific "break throughs" in medical skills, techniques, medications, and supportive institutions. This has truly been a rewarding and humbling experience.

I am here today to present testimony to you on a mix of congressional bills and resolutions all of which are concerned with health manpower and medical care legislation which is intimately involved with the medical component of the Veterans' Administration activities. During past years I have served as President of the Medical Society of the State of North Carolina as well as national president of the American Academy of Family Physicians (general practice) which has a membership of 32,000 physicians and, largely, speaks for an additional 40 or 50 thousand physicians who practice as family physicians. At various times in the past I have spoken as official representative for these organizations. However, today I present my own personal assessment and views on the legislation at hand. Neither the legislative council nor the board of directors of the American Academy of Family Physicians have reviewed this legislation in depth. Therefore, as of now, the American Academy of Family Physicians has no established policy either in support or in opposition to this legislation.

Having presented this preamble, let me get to the business at hand:

For too long now, I think the Veterans' Administration's medical efforts have been excluded or separate from the mainstream of both the medical services and medical institutional progress which has been developing in this country. There is reason to believe that this divisiveness which has hindered the excellence of medical productivity as well as the comprehensiveness of services available in Veterans Administration medicine has eventuated from two sources.

Enabling legislation which established and has thus far directed the course of Veterans Administration medical productivity has been unnecessarily restrictive. The categorical restrictions which made of this medical venture essentially—a remedially oriented-in-hospital based-medical service program to care for only service connected illnesses and disabilities for armed services veterans—was productive of predetermined failure. Any medical program thus isolated and insulated from ongoing progress in the areas of medical investigation and research, medical education, and the provision of a full range of medical services, as well as progressive health maintenance programs must, of necessity, be mediocre in its productivity.

If there had not been some imaginative leadership in the office of the medical director of the Veterans Administration over recent years this program would be further retarded than it presently is. By the recent innovation of building veterans hospital facilities in close proximity to medical schools and medical educational centers much has been done to upgrade this whole program as relates to availability and quality of services.

I have had frequent personal experiences, over my years of practice, which illustrate the immense importance of having Veterans Administration medical facilities participant in the mainstream of current medical research, education, and provision of high quality medical services. For many years the Veterans Administration hospital in Fayetteville, North Carolina was the only source of referral hospitalization for veterans in my personal practice. This hospital falls in the general category of isolated veterans hospitals which I discussed previously. The dependable or predictable quality of medical services available at Fayetteville were of such mediocrity that I could not justify sending to this hospital acutely ill patients who were in dire need of sophisticated medical services. These patients I sent to medical centers at Duke University or the University of North Carolina where, of course, they were required to pay full charges for their professional services and hospitalization. It was better to return home alive and in debt than to return home in a hearse.

Now, there is a relatively new, well equipped and expertly manned Veterans Administration hospital within the equivalent of three city blocks of Duke University Medical Center. There is every evidence that the quality and sophistication of medical care which my patients receive in this new Veterans Administration hospital is the reasonable equivalent of that which they would receive at the Duke University Medical Center. Factually, these two adjacent medical facilities are so intermingled and entwined from the standpoint of personnel, facilities, and responsibility—as to be totally co-equal. Now—I can refer my patients who are eligible for Veterans Administration medical care to Fayetteville if their illness is chronic or less severe. Those patients who are in dire need of astute and sophisticated medical care now go to the Durham Hospital which is adjacent to and medically equivalent to the Duke University Medical Center.

The second, or other, factor involved in the mediocrity of Veterans Administration medical care over the years deals with the inability of the isolated Veterans Administration hospitals to attract and retain skilled personnel. I am now speaking of skills and productivity at the levels of physicians, nurses, administratives, etc. These institutions, by virtue of their legislated restrictions and isolation from the challenges and inspiration evidenced in teaching and research oriented medical centers, were, and still are, unable to maintain staff and personnel productive of a full spectrum of high quality medical care. The chief source of physicians on the medical staff of remote Veterans Administration hospitals are from physicians who are semi-retired, those who have chronic illness which limits their activities, and those who do not anticipate nor meet the challenge of the competitive practice of medicine. It is my opinion that essentially no amount of financial remuneration—alone—could or would remedy this situation.

Then, too, the composite attitude of the more than 300,000 physicians in the United States as relates to Veterans Administration medicine in general has not been health. Until the recent advent of the teaching and research medical center affiliation of the Veterans Administration hospitals, very few, if any, physicians who accepted employment in Veterans Administration hospitals gained face or stature among their medical colleagues. Until the main thrust of the attempt to adequately staff the Veterans Administration's medical effort relates much more to medical education, scientific medical research, health care delivery systems research, and continuing health education efforts, intimately affiliated with the whole cross section of medical education and progress, very little of progress will be evidenced.

Mr. Chairman, I have spent much of my time here today in an attempt to document in the recorded history of this present legislation, through these hearings here today, the absolute reasons why this proposed legislation dealing with Veterans' Administration health manpower training and medical care enabling legislation must be enacted and funded by this Congress. You, Mr. Chairman, and those others in both Houses of this Congress of the United States who have thought through and proposed this innovative legislation have done much for the future of Veterans' Administration medicine in particular and for the continued progress and advancement of health and medical care in general.

Mr. Chairman, basically I am in personal support for all of the innovative concepts embodied in S. 2219 and other associated legislation under consideration here today. Each of these concepts and legislative proposals embodied in these bills already have been spoken to eloquently and with great understanding. I shall not burden you—and those others here today—by repetitious discussion. There are a few points I would like to make about areas involved which are of special concern to me.

I am not sure exactly how many additional physicians we have need of today. It is glibly said by many people that our physician manpower pool is short by 50,000 physicians at the present time. I am not at all sure that the expense of supporting 50,000 additional physicians who were trained to provide medical care by the same pattern as currently exists might not bankrupt the financing of medical care and destroy the present delivery system. There is need for more physicians trained to provide primary or first contact medical and health care. There is need of more physicians trained as family physicians to be the prime mover in the team health care delivery system. There is need for many more adequately trained physicians assistants, nurse practitioners, med-ex trainees, nurses in general to work with the team approach to health and medical care so that we may expand by 30 to 50% the productivity of those physicians which we now have available. This team concept should embody the certainty of available medical care 24 hours per day—7 days per week. The emergency room of any or all hospitals is not and can not be the substitute for adequate medical care from 5 p.m. to 9 a.m. on weekdays, nor from Friday evening until Monday morning on weekends. Much of this concept is embodied in legislation before us today which can be productive of much good if it can be implemented properly.

Regardless of how many physicians we have a shortage of in this country today, we can not justify perpetuating the sources from which we obtain many of our physicians today. We can no longer justify the procedure of piracy by which we take physicians for our own country who are educated in underprivileged and underdeveloped countries who need physician manpower considerably more than we in America do. We must expand our medical education effectiveness to be productive of as many physicians as well as other health manpower personnel as we need.

Medical education in this country has let down the people in this country who have supported medical education handsomely. Under the pretext of the *pursuit of excellence* in medical education to the *point of diminishing returns*—medical education has restrained and contained the productivity of physicians and ancillary medical manpower to the creation of a woesome deficit in this commodity in our country.

In S. 2219—Section 5073—titled "grants" on page 17—subsection (2) I see evidence of the fine finger of the association of American Medical Colleges, "there is reasonable assurance from a recognized accrediting body or bodies approved for such purposes by the commissioner of education of the Department of Health, Education, and Welfare that the increase in the number of students will not threaten any existing accreditation or otherwise compromise the quality of the training at that institution". Gentlemen, this is the "medical mafia" writing the unilaterally oriented ground rules for the game in which they participate. This is the heirarchy of medical education controlling the productivity of medical education. Many, many physicians intimately involved in medical education who are not "card carrying members" of the AAMC will tell you that most medical schools could double their output of physicians within a short few years, and yet retain the excellence of their graduates, if they were properly stimulated. Those of you in the Congress should not be misled by this hocus-pocus of "loss of accreditation" by medical schools for rapidly increasing their student bodies.

It is a sad state of affairs when local legislation at a state level, i.e., California and others, is passed to permit the return of American citizens—American medical students—from schools in Mexico, the University of Acapulco in particular, which may have as high as 1000 medical students per class. These American students go to this and other foreign schools, the majority of whom are academically far inferior to American schools, because they are denied admission to American schools.

I would suggest that medical education in America be supported, per se, as medical education by specifically ear marked tax funds, both Federal and State. I would also suggest that scientific medical research be supported in a similar manner. Then both education and research could live symbiotically together in the same community and be each highly productive. Under these circumstances medical education would not be funded from the process of "skim off and drip through" from unusually large grants assigned to specific scientist-teachers or to certain departments of medical schools which scientists or departments then control the destiny of medical education in the various medical schools. Funding, specifically appropriated for medical education as such might then be tagged with gentle reminders of productivity expected in return for financial support.

One last thing: some sort of participation in an ongoing educational process or program in as many V.A. hospitals as possible is essential. This can be a joint venture in residency training programs with a local public or private non profit hospital. This also could be a program to train ancillary health and medical personnel. This, combined with a meaningful continuing medical education program which would be affiliated with an available teaching medical center, could mean much to the quality of health care available not only in the local V.A. hospital and local community general hospital, but to every community with physician coverage in a whole large area. Specifically, I know that a medical school in North Carolina is interested in a residency training program, specifically in family practice, in the public community hospital in Asheville. Also, this teaching center is interested in a meaningful continuing educational program for a 12–15 county region of western North Carolina which would also involve areas of 3 other adjacent States. Should the quite sizeable V.A. hospital facility in Asheville be permitted, or mandated, to be cooperative in this joint venture of a family practice residency plus a continuing education regional program this would, of necessity, make for higher quality health and medical care for a large area of many people which now suffers for the want of such a program.

Legislation being considered here today supports such programs as outlined above. This legislation would also support various modifications of such programs in almost all of our States, territories, and possessions. I would urge that we all work for the enactment, funding, and implementation of this proposed legislation with its many potentially advantageous and productive components.

In reality I think that the Veterans Administration medical facilities and system has considerable of potential to offer to American medicine just as American medicine has much to offer to V.A. medicine. This being so, then, lets get on with the job. Thank you very much for allowing me to be heard here today.

Senator **Cranston**. Our next witness is Dean William Feagans, School of Dentistry, State University, Buffalo, N.Y.

Dean Feagans, I am grateful to you for your presence and for your waiting. I would appreciate if you would submit your full statement and summarize your testimony and comments on this morning's discussions.

STATEMENT OF WILLIAM M. FEAGANS, DEAN, SCHOOL OF DENTISTRY, STATE UNIVERSITY OF NEW YORK, BUFFALO, N.Y.

Dean **Feagans**. As a dean of a dental school I naturally share your concern over the quality of health care available to veterans. In the dental area present staff levels and facilities are inadequate to provide even the basic care needed by patients in many Veterans' Administration hospitals. In Buffalo, for example, there are only six staff dentists for an inpatient population of approximately 800.

The clinic also serves the outpatient needs of eligible veterans in a metropolitan area of 3 million people. This includes the eight western

New York counties and also Rochester and parts of Pennsylvania. This facility is so overworked that our dental school is now sending members of our faculty in the evenings and Saturdays to help meet the needs of the patients. Many of these patient services could just as easily be provided by students under staff supervision.

In considering ways to alleviate the shortage of physicians and dentists, it is, in my opinion, not enough to only increase the numbers of new graduates. Increasing the productivity and efficiency of existing professionals through use of paraprofessional personnel will make a substantial contribution to better health care for more people, including veterans.

At the present time there is a major thrust in health professional education to redefine and enlarge the responsibilities of allied health personnel such as physicians' assistants and dental therapists. I have introduced the term "dental therapist" here merely to avoid some confusion between the contemporary auxiliary, the "dental assistant" and the proposed "dentist's assistant" frequently referred to in current health legislative proposals. By "dental therapist" I mean a new auxiliary who will perform many of the repetitive, task-oriented procedures now performed by the dentist.

Because the VA hospital is not limited by State licensing restrictions, it offers a unique setting for research in new modes of delivery of health care services.

In considering ways to improve the availability and quality of care for veterans, I see two major areas of concern. The first, obviously, is to provide an adequate level of health care by:

1. Improving and expanding hospital facilities;
2. Increasing salary schedules to make the VA hospitals more competitive;
3. Continuing to strengthen the existing affiliations with health professional schools and to utilize more fully facilities and personnel for educational programs;
4. Upgrading the skills and knowledge of health professionals in order that the VA hospitals could serve the "Regional Medical Education Centers";
5. And, finally, by developing workable programs stressing maintenance of health and the prevention of disease.

The second task is to provide additional educational opportunities for veterans to translate service-acquired skills and knowledge into productive civilian careers. With only a minimal amount of additional training these veterans will provide the health community with a valuable pool of allied health personnel.

A program such as outlined in S. 2219 will greatly improve the quality of veteran health care. It will also provide these veterans with needed jobs in fields where shortages already exist and will get worse as essential health services are made available to all the people.

In addition, there are many veterans, including those disabled or handicapped, returning from active service today who are in critical need of learning a marketable skill in order to earn a decent living. Laboratory technology is an ideal skill for the handicapped or disabled veteran. Experience has shown that the handicapped person is able to develop certain exacting skills to a higher degree of proficiency than a more active person: watchmaking is a good example of this.

Most of the work in dental laboratory technology is conducted while seated at a workbench. There is no reason why a paraplegic could not become an extremely skilled and valuable technician.

However, before a large and continuously growing number of paraprofessionals can be fully absorbed and utilized within our health care system, a strenuous effort must be made to upgrade the skills of medical and dental practitioners who may never have relied on allied health professionals to any degree.

Today many graduating physicians and dentists are trained to routinely work with allied health professionals, and their role is fully understood and appreciated. This is not always true, however, with older conventionally trained medical and dental practitioners. The reeducation of these physicians and dentists to accept and fully utilize the skills and knowledge of paraprofessionals is just as important as the training of the paraprofessionals themselves.

Continuing education programs and postgraduate enrichment programs that will reach out to these traditionally trained practitioners are vitally necessary and I strongly urge you to enact Senate bill 2355. This bill recognizes the fact that traditional continuing education programs are not enough. One cannot retrain a dentist to use paraprofessional personnel and work as a team by a lecture in a classroom or on a TV monitor. This requires actual chairside learning in patient care.

If ever continuing education had a challenge, it is today. With the burgeoning information and new therapeutic skills being developed, the practicing health professional must broaden his sphere of knowledge and skills. It requires taking continuing education programs to the patient's bedside, the research laboratory or the dental chair. But clinical continuing education programs requiring patients and follow-up care are extremely expensive for schools to conduct and, unfortunately, are often the first programs to feel the pinch of reduced budgets and support.

The VA could help speed the optimal utilization of paraprofessionals by:

1. Making facilities and staff available for continuing education programs;
2. Providing financial support for VA-affiliated health professional schools for expanded continuing education programs. These should be specifically designed to improve and increase the use of allied health professionals.
3. Providing a constant pool of patients for these programs. This would make high quality care available to VA patients at a low cost while at the same time providing an educational opportunity for the practitioners and the paraprofessionals.

In Senate bill 2219 the case for comprehensive health care is stated well. When one talks of comprehensive care, one is referring to oral health care, too. Training and education of dental students must reflect the team care concept. Therefore, a portion of their training must be within the hospital setting. Dental students need a modified clerkship in certain medical services, for example, in medicine and anesthesiology.

In addition, courses in physical diagnosis and laboratory medicine could easily be offered in the VA hospital. At the present time, however, both facilities and staff are inadequate to accommodate these aspects of our educational program.

In closing I want to thank you for your untiring efforts to upgrade the level of health care for all Americans and specifically for our deserving veterans. As a member of academic dentistry I commend you for making appropriate provisions to insure the delivery of oral health care.

Senator CRANSTON. Thank you for your helpful and very much to the point testimony. I would like to ask you a few questions.

I was very interested to note that you feel the VA system offers a great opportunity for experimentation in new ways of providing health services and particularly in development of new kinds of health personnel. What are your thoughts on the potential of new auxiliaries in the dental area, the kinds of services they could provide, and the degree of autonomy they could be assigned?

Dean FEAGANS. I think most dental educators now have the ideas for new and workable innovative approaches utilizing auxiliaries with expanded functions. Unfortunately we are beset with problems. One is funding of these programs and, two, is the present restrictions of the State practice acts. I feel, as I indicated earlier, that the VA hospitals can offer ideal settings for experimentation in new modes of health care delivery.

Senator CRANSTON. I understand some studies are being sponsored to determine how best the veteran with experience in providing dental service can translate his experience and training to the civilian sector. You state a minimum amount of training is all that is needed to make these veterans productive members of the civilian community.

How do you envision this training being provided?

Dean FEAGANS. Many of them are already trained to the point where they could work into the roles of the new auxiliaries with anywhere from 6 to 10 months of additional training, if the State practice acts were modified to permit them to work with dentists in the community in actual practice situations.

Senator CRANSTON. Can this be provided in a VA facility?

Dean FEAGANS. Yes, sir, it can be.

Senator CRANSTON. Is some academic work required that can only be provided in colleges or universities?

Dean FEAGANS. That is correct.

Senator CRANSTON. How much?

Dean FEAGANS. It would depend on the amount and type of previous training the veteran had received. For a program in dental technology, for example, we would be talking about 1 year of academic work.

Senator CRANSTON. Should this training be provided in conjunction with the schools of dentistry?

Dean FEAGANS. It certainly should work cooperatively with dental schools. I also think some programs can be developed in area community colleges.

Senator CRANSTON. Your discussion of the potential of continuing education programs in acquainting older conventionally trained medical and dental practitioners with proper utilization of new types of paraprofessionals makes an important point. That is, the education of these professionals in the utilization of auxiliaries is just as important as the education of the auxiliaries themselves.

At the school of dentistry do you have programs for team training of dentists and auxiliaries together?

Dean **Feagans**. We have such a program for students but not for practicing dentists. We have submitted a grant application for team training of auxiliaries with dentists. However, at the present time, there are no programs or funds to bring traditionally trained dentists into the school and show them how they can use these people effectively.

I might add we have endorsement from local organized dentistry, the Eighth District Dental Society, to get involved in experimentation of expanded functions of auxiliaries.

Senator **Cranston**. You have such training in VA facilities?

Dean **Feagans**. Not at present.

Senator **Cranston**. Are there any plans to do that?

Dean **Feagans**. We investigated the possibility of such a program with the VA, but we were told there were inadequate funds.

Senator **Cranston**. In your affiliation with the VA facility at Buffalo, or in connection with it, to what extent have your training programs been restricted by lack of staff, equipment and space?

Dean **Feagans**. Right at the present our fourth year students rotate in groups through the VA hospital, which is directly across the street from the school of dentistry. Because of the inadequate facilities and the inadequate number of staff, their role there is purely one of observation. At the present, they are not directly involved in patient care.

Senator **Cranston**. You refer to the inadequate capacity of the Buffalo VA Hospital to provide basic dental care for patients in that area, what kind of additional staff is needed to provide that care? What limitations exist in the ability of VA to do the job?

Dean **Feagans**. I think now they have six staff dentists. If we are to get our students involved where we are administrators of health service, then I would imagine that the physical facility and staff would have to be enlarged twofold at least.

Senator **Cranston**. Thank you very much. You were very helpful. You are the only man from your vantage point testifying today, and we are grateful for your appearance.

Dean **Feagans**. We appreciate that you have incorporated other health professions within your bill, sir.

Thank you.

(The prepared statement of Dean Feagans follows:)

STATEMENT OF WILLIAM A. FEAGANS, D.D.S., PH. D., SCHOOL OF DENTISTRY, STATE UNIVERSITY OF NEW YORK, BUFFALO, N.Y.

Mr. Chairman. My name is William M. Feagans. I am Dean of the the School of Dentistry at the State University of New York at Buffalo. I welcome this opportunity to support the proposed Veterans Administration Health Manpower Training Act of 1971—S. 2219 and Bill S. 2355, the proposed "Veterans Administration Continuing Medical Education Act."

As a dean of a dental school, I naturally share your concern over the quality of health care available to veterans. In the dental area, present staff levels and facilities are inadequate to provide even the basic care needed by patients in Veterans Administration Hospitals. In Buffalo, for example, there are only 6 staff dentists for an in-patient population of approximately 800. The clinic also serves the out-patient needs of eligible veterans in a metropolitan area of 3,000,000 people. This includes the 8 Western New York counties and also Rochester and parts of Pennsylvania. This facility is so overworked that our dental school is now sending members of our faculty in the evenings and Saturdays to help meet the needs of the patients. Many of these patient services could just as easily be provided by students under staff supervision.

In considering ways to alleviate the shortage of physicians and dentists, it is, in my opinion, not enough to only increase the numbers of new graduates. Increasing the productivity and efficiency of existing professionals through use of paraprofessional personnel will make a substantial contribution to better health care for more people, including veterans. At the present time, there is a major thrust in health professional education to redefine and enlarge the responsibilities of allied health personnel such as physicians' assistants and dental therapists. I have introduced the term "dental therapist" here merely to avoid some confusion between the contemporary auxiliary, the "dental assistant", and the proposed "dentist's assistant" frequently referred to in health legislative proposals. By dental therapist, I mean a new auxiliary who will perform many of the repetitive, task-oriented procedures now performed by the dentist.

Because the VA Hospital is not limited by state licensing restrictions, it offers a unique setting for research in new modes of delivery of health services.

In considering ways to improve the availability and quality of care for veterans, I see two major areas of concern. The first, obviously, is to provide an adequate level of health care by:

1. Improving and expanding hospital facilities.
2. Increasing salary schedules to make the VA Hospitals more competitive.
3. Continuing to strengthen the existing affiliations with health professional schools and to utilize more fully facilities and personnel for educational programs.
4. Upgrading the skills and knowledge of the health professionals in order that the VA Hospitals could serve as "Regional Medical Education Centers."
5. And finally, by developing workable programs stressing maintenance of health and the prevention of disease.

The second task is to provide additional educational opportunities for veterans to translate service-connected skills and knowledge into productive civilian careers. With only a minimal amount of additional training these veterans will provide the health community with a valuable pool of allied health personnel.

A program such as outlined in S. 2219 will greatly improve the quality of veterans health care. It will also provide these veterans with needed jobs in fields where shortages already exist and will get worse as essential health services are made available to all the people. In addition, there are many veterans, including those disabled or handicapped, returning from active service today who are in critical need of learning a marketable skill in order to earn a decent living and develop a sense of usefulness. Because of its exacting and confining nature, dental laboratory technology is an ideal skill for the handicapped or disabled veteran. Experience has shown that the handicapped person is able to develop certain exacting skills to a higher degree of proficiency than a more active person: watchmaking is a good example of this. Most of the work in dental laboratory technology is conducted while seated at a workbench. There is no reason why a paraplegic could not become an extremely skilled and valuable technician.

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Senator CRANSTON. The next witness is Mr. Francis Stover, national legislative director, VFW.

STATEMENT OF FRANCIS STOVER, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. STOVER. Thank you, Mr. Chairman.

I had hoped to have Norman Jones join me.

Senator CRANSTON. If you could summarize your statement, we will be grateful.

Mr. STOVER. We thank you for holding these hearings.

The VFW has always singled out the Office of Management and Budget and its predecessor, Bureau of Budget, for not taking advantage of the VA hospital system. We feel that the anti-veteran bias which has been demonstrated in the Bureau of Budget over a period of years is the major reason why the Veterans' Administration has not been recommended for a much larger and more significant role in the meeting of the health crisis with which this Nation is faced. That is one of the reasons why the VFW is supporting House Joint Resolution 748, the bill that would establish five medical schools in conjunction with the VA facilities, which hopefully will make a dent in reducing the tremendous shortage of doctors, estimated to be 50,000, and also help to reduce the shortage of other medical personnel.

We commend you for holding hearings on House Joint Resolution 748 and Senate Joint Resolution 76, introduced by Senator Bentsen, of Texas, and cosponsored by the distinguished majority leader, Mike Mansfield, and your bill, Mr. Chairman, S. 2219, and the cosponsors.

With respect to your Omnibus Medical Care Act of 1971, the Veterans of Foreign Wars by national mandate supports the proposition that women and children; that is, wives and children of veterans who are permanently and totally service-connected disabled or the widows and children of those veterans who died from a service-connected death should be provided VA hospital care where feasible.

Our organization, has had some difficulty with extending VA hospital care to dependents of veterans. A resolution was considered and adopted by the delegates that this small group of dependents should be entitled to VA medical and hospital care. I stress this because some feel we are opposed to it. We are not.

We have also had quite a bit of heat, I guess you would call it, on our organization in reference to the nursing home program operated by the VA which we call hometown nursing care. We feel that veterans should be directly admitted to these nursing homes and that the VA should not be required to take veterans in a VA hospital for active hospital care and then transfer them to a nursing home.

We feel that this should be done wherever there is a medical determination that they are actually nursing care cases at time of admission.

In reference to the recruitment and retention of personnel in VA hospitals, I notice one of the bills here would make some improvements in that area. Again hospitals operated by the VA in remote areas which are not connected with medical schools or where there is an absence of a medical community—it is difficult for VA to recruit and after recruiting to keep people in those areas.

We have always supported legislation which would make such service in those so-called remote hospitals more attractive.

I think that these bills are very important in that area.

The VFW supports your bill to insure that VA hospitals meet safety standards. We shared the shock of everyone when the San Fernando VA Hospital was completely destroyed by an earthquake. I might add there was another one in Biloxi, Miss., that suffered severe damage by hurricane, and another one in North Carolina because of tornado.

So we do feel that the construction of all VA hospitals should meet the highest standards.

These, Mr. Chairman, are the highlights of my testimony and I would be glad to answer any questions that you may have.

Senator CRANSTON. Thank you very much. I want to particularly thank you for appearing personally on such very short notice. It is very cooperative of you and your testimony is very helpful.

I would like to ask about the point you make in your prepared statement, about the failure by the administration to recommend the VA for a more significant role in helping meet health care needs of the Nation. I think you put your finger on the reasons for it, the OMB.

I appreciate your support of the purpose and intent of these proposals to broaden the mission of the Veterans' Administration. Respecting quality and quantity of medical care under the control of the VA, you indicate support by the VFW for House Resolution 748. I presume that means support also for S. 2219?

Mr. STOVER. That is correct. Both the House bill and your bill S. 2219 would accomplish the same purpose.

Senator CRANSTON. Where you referred to the need—in your prepared statement—for helping widows and children of veterans who are permanently and totally disabled, I assume you support outpatient care for them as well as hospital care?

Mr. **Stover.** That is correct. The theory is they are stepping into the shoes of their disabled or deceased parent and therefore are entitled to the same care and treatment as the disabled or deceased veteran.

Senator **Cranston.** In regard to your August national convention, I regret I cannot be there this year. I have some conflicts in my schedule. We will hold the record open for any pertinent resolutions.

Will you comment on the need for support of this expansion of VA authority to provide health care? I presume that you do favor the expansion of outpatient care as in S. 2354, my bill, and S. 1924, the administration bill.

Mr. **Stover.** Our philosophy, our position basically, is that we would like to eliminate any legal restrictions to prevent the VA from providing maximum care in the most efficient and least costly manner. Sometimes it is better they treat them at a veterans' home rather than admit them to a VA hospital and go through a fiction in order to accomplish this.

These bills, I think, are within that philosophy.

Senator **Cranston.** I very much apprecite your support and your testimony and your personal presentation. Thank you very much.

(The prepared statement of Mr. Stover follows:)

STATEMENT OF FRANCIS W. STOVER, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and Members of the Subcommittee: Thank you for the invitation to appear before this distinguished Subcommittee to present the position of the Veterans of Foreign Wars on this legislation to improve hospital and medical care for veterans.

Each year the Veterans of Foreign Wars holds a National Convention at which time a large number of resolutions are adopted by the Convention delegates. At our most recent National Convention, which was held in Miami Beach, Florida last August, a number of resolutions were adopted which are germane to the bills under consideration.

These resolutions cover a wide range of subjects and several represent the official position of the Veterans of Foreign Wars concerning these proposals. With your permission, Mr. Chairman, it would be deeply appreciated if the full texts of these resolutions, identified as Number 1, Halt Reduction of VA Hospital Beds; Number 8, Veterans Administration Department of Medicine and Surgery Program; Number 89, Direct Admission of Veterans to Nursing Homes, and Number 128, Veterans Administration Department of Medicine and Surgery Program, be made a part of my remarks.

Mr. Chairman, the Veterans Administration operates the world's largest medical complex. There are VA hospitals in every state of the Union except Hawaii and Alaska. The Veterans Administration has 165 hospitals with three more scheduled to open this year, making it a total of 168 hospitals. There are 16 VA domiciliaries, which are described loosely as equivalent to soldiers homes. In addition, the Veterans Administration operates 200 clinics and 76 nursing homes. The Veterans Administration operation is the largest hospital, medical chain in the world. In these facilities the Veterans Administration conducts a comprehensive and extensive research program. Its education and training programs are a continuing activity for the purpose of improving its own medical staff. Veterans Administration hospitals over the years have helped train about one half of the graduate physicians each year. A large number of other medical personnel, such as doctors assistants and medical specialists are also trained at Veterans Administration hospitals each year.

Despite this tremendous education and training program by the Veterans Administration, the potential has hardly been tapped. All are agreed that today America is suffering from a national health crisis. National Health Insurance is under active consideration by the Congress and the Administration from President Nixon on down. A number of health care proposals are before the Congress and under consideration by Congressional Committees.

In spite of this intense interest and activity respecting national health care, there seem to be few proposals which contemplate fully utilizing the large hospital chain we have in the Veterans Administration. Many have questioned why the Administration has failed to recommend the Veterans Administration for a more significant role in helping to meet the health care needs of this Nation. We in the Veterans of Foreign Wars believe that the answer is in the Office of Management and Budget and its predecessor, the Bureau of the Budget.

These budget planners have demonstrated an anti-veteran bias over a period of many years. This veterans prejudice is probably the root cause of why successive Administrations have failed to make recommendations to relieve the shortages of doctors and other medical and health personnel which the Veterans Administration is ready and capable of providing.

We believe the Office of Management and Budget has done a gross disservice to the Nation by not taking advantage of the greatest potential for education and training which the Veterans Administration can provide.

It is most encouraging, therefore, that these hearings are being held. The bills before this Subcommittee are aimed at improving the quality of medical care for veterans. Several are in the area of providing authorization to the Veterans Administration to grant assistance in establishing state medical schools and making other arrangements with universities and health institutions. The V.F.W. supports the purpose and intent of those proposals which will broaden the mission of the Veterans Administration respecting its contribution to the quality and quantity of medical care so long as the program is under the dominion and control of the Veterans Administration.

The Veterans of Foreign Wars supported H.J. Res. 748, the House approved bill, which would authorize the Veterans Administration to assist in establishing five new state medical schools in five widely dispersed areas of the country. This bill would authorize the Veterans Administration to cooperate with not more than five states to establish state medical schools which are badly needed. The shortage of doctors is now estimated to be about 50,000. There is another 250,000 shortage of medical personnel such as nurses and medical specialists. H.J. Res. 748 and similar bills, such as S.J. Res. 76, would not only be in the best interest of improving care for veterans, but would make a significant contribution to the health care of the Nation.

Similarly, the Veterans of Foreign Wars has always supported legislation which will improve the recruitment and retention of medical personnel in Veterans Administration hospitals, especially personnel in remote areas. Generally, where there is an absence of a medical community, it is most difficult to recruit and retain medical personnel. This is another justification for H.J. Res. 748 and similar bills, which will be very helpful in improving medical care in those areas where there is no affiliation with local medical schools.

The Veterans of Foreign Wars supports the proposal for direct admission to nursing care units in VA facilities and hometown nursing care under the auspices of the Veterans Administration. Presently, the veteran is required to be hospitalized in a VA hospital and then transferred to a nursing home in or near the veterans hometown. The present practice causes administrative waste.

The Veterans of Foreign Wars supports Veterans Administration hospital care for wives and children of veterans who are permanently and totally disabled, and the wives and children of servicemen killed on the battlefield or who died from service connected causes. The underlying philosophy here is that the widows and children step into the shoes of the veteran who is forever permanently and totally disabled or died of service connected causes. The Veterans Administration provides education and housing assistance for this group. Extending hospital entitlement where feasible would be an extension of this kind of assistance to the immediate families of servicemen who have made an extra sacrifice in the national interest at the expense of their life and health.

The Veterans of Foreign Wars shared the shock of all Americans when the San Fernando Veterans Administration hospital was totally destroyed by an earthquake. The Veterans of Foreign Wars, therefore, supports Senator Cranston's bill which will insure that Veterans Administration hospitals meet all fireproof, earthquake and other national disaster standards. Two other Veterans Administration hospitals have suffered damage in recent years, including the VA hospital in Biloxi, Mississippi which was damaged by a hurricane and another hospital in North Carolina which was damaged by high winds. We must never cease in making sure all Veterans Administration hospitals will meet the highest standards.

The Veterans of Foreign Wars does not have any official position respecting the other provisions in S. 2354 and related bills. The record should show that our Organization is scheduled to hold our 72nd National Convention in Dallas, Texas, August 13–20, 1971. I am sure that the proposals contained in these bills will be presented in the form of resolutions to the delegates at our Dallas Convention. Any and all positions taken by the delegates respecting these proposals will be furnished to this Subcommittee and the Congress as this legislation advances.

These, Mr. Chairman, represent the views of the Veterans of Foreign Wars respecting these proposals. It is strongly recommended that favorable consideration be given to those bills and proposals which carry out the mandates of our Organization as indicated in the attached resolutions and this testimony.

Thank you.

Senator Cranston. Due to our inability to track down other witnesses scheduled for later in the afternoon, we will now recess until 1:30 p.m.

(Whereupon, at 12:55 p.m. the subcommittee recessed, to reconvene at 1:30 p.m. of the same day.)

AFTER RECESS

(The subcommittee reconvened at 1:30 p.m., Senator Alan Cranston, chairman of the subcommittee, presiding.)

Senator Cranston. The hearing will come to order.

Our next witness is Senator Moss. I am delighted to see you here, Ted, and look forward to hearing your testimony.

STATEMENT OF HON. FRANK E. MOSS, A U.S. SENATOR FROM THE STATE OF UTAH

Senator Moss. I appreciate this opportunity to testify; I know you have been sitting long on the hearings today and I will try to stick with my text.

I am grateful to you for holding these hearings, which include S. 1635, which is a bill I introduced for payment of night differential and premium pay for VA nurses. It has been before the Congress since early in the 91st Congress and this is the first time hearings have been held on it, although I pressed for consideration a number of times. So, naturally, I am delighted this problem is being given an airing.

The bill was first introduced in July 1969 in response to a petition I received at that time from nurses at the VA hospital in Salt Lake City. A personal letter I received recently from one of the nurses at the hospital expands the information in the petition and explains far better than I can the conditions to which the nurses object. I quote:

> I have been a nurse at the VA in Salt Lake City, Utah, for 15 years and although I enjoy my job and plan to continue to work here until retirement, I appreciate the opportunity to list my particular areas of discontent.
>
> 1. Nurses frequently must work seven to ten days consecutively, without a choice or additional pay.
>
> 2. Nurses frequently work at least half or three-quarters of all legal holidays and get a compensatory day off sometime in the future. It is common practice to work Christmas Day, for example, and receive the compensatory day in the middle of January. It isn't much fun and most of us would much prefer to be paid for the holiday. Usually we have a choice of one of the three holidays off, either Thanksgiving, Christmas or New Year's, but we generally work the other two.
>
> 3. VA nurses work at least two or three and sometimes four weekends in one month's time without acknowledgement of any sort. Nursing assistants who work right along with us are being paid additional for working Sunday. Consequently,

> there is much squabbling between nurses over weekends off. If nurses were paid additional for Sunday work, we would probably squabble in the other direction, but we would be cheerful about it.
>
> 4. VA nurses are hired with the understanding that they are to work whatever shift they are assigned. Sometimes that includes three different shifts in one week, although it is usually more like two; at any rate many nurses would prefer to work in private hospitals where they have more choice of shifts and are paid differential for the evening and night tours of duty.

It is clear from this letter that registered nurses employed by the Veterans' Administration's Department of Medicine and Surgery are denied fringe benefits provided nurses in non-Federal employment. These benefits include shift differentials for evening and night work, overtime, holiday and on-call pay and, in some instances, time off. It is high time we authorize the Administrator of Veteran's Affairs to make appropriate payments in these areas.

Enactment of the premium pay provisions provided in S. 1635 is essential if the VA is to recruit and retain enough registered nurses to provide quality care for our disabled and ill veterans.

It is even more important that we take action now than it was 2 years ago because VA hospitals are under added strain through increased patient loads from Vietnam. We owe better care to these Vietnam veterans than they are getting. And we owe more consideration to the nurses who are struggling under the increased caseload to give them good care.

In the last few years salaries for registered nurses in public and private hospitals have been increasing at a faster pace than for nurses in the VA. This is especially true in States with large metropolitan areas. The VA has attempted to keep pace by increasing the entrance salaries for junior grade, associate grade and full grade nurses at 74 locations. But this has not been enough to attract and hold the necessary nursing staff.

Nurses in VA hospitals work under trying conditions because of a high nurse vacancy rate as well as many other shortages, both professional and subprofessional, in medical and nursing personnel categories. Because of the staffing shortage, nurses are required to work 7- and 8-day stretches on all tours of duty without compensating overtime or pay differentials. This single condition is credited with the high turnover rate, especially among the new nurses entering the VA system.

VA nurses are required by agency policy to be on call 7 days a week, 24 hours a day unless excused by proper authority. They are required to rotate to all three tours of duty so that wards may have professional nursing coverage 24 hours a day. Operating room nurses take call every other week in addition to their regular schedule. It takes a special dedication for this sort of duty.

It is for this reason that my bill provides a standby or on-call pay, and it is unique in this respect. Operating room staff have to remain at their residence or leave a phone number where they can be called in the event of emergency operations. They must remain within 30 minutes of the hospital. This is not an occasional happening. The staff is regularly required to take call. For this there is no compensation. My bill would provide a differential of 25 percent for nurses required to remain in a standby status subject to callback.

The report published by the House Committee on Veterans' Affairs on February 17, 1971, reveals that registered VA nurses worked an average of 2 uncompensated hours in excess of 40 hours per week during the report week of November 24–30, 1970. Morale is low and this also has made it difficult to retain newly hired nurses.

Mr. Chairman, enactment of S. 1635 will take a giant stride toward improving the working conditions of a dedicated group of professionals engaged in the vital area of nursing practice. VA nurses have been asking for premium pay for many years. We cannot permit this situation to continue any longer.

The American Nurses Association supports my bill, and I understand that a representative of the association is here to testify in behalf of it today.

And now thank you for hearing me.

Senator CRANSTON. Thank you, Senator Moss. You provided the leadership in this effort in the last session of Congress.

Your bill, S. 1635, is quite similar to some provisions in my bill which is an omnibus bill covering many other points, and we have taken many of your ideas and have them in that bill.

We are thankful to you for your leadership. I am sure we will be able to move legislation in the direction you recommend we do.

Your bill is nearer to what I think will be the way we go than the administration bill, S. 1924. We appreciate your leadership and help and your testimony today.

Senator MOSS. Thank you, Mr. Chairman. I appreciate that and I appreciate your pressing forward in this area. It is to rectify inequity and if we can do that, it certainly will improve the morale in VA hospitals.

Senator CRANSTON. Our next witness is Dr. Thomas F. Jones, president, University of South Carolina, Columbia, S.C.

STATEMENT OF DR. THOMAS F. JONES, PRESIDENT, UNIVERSITY OF SOUTH CAROLINA

Dr. JONES. Mr. Chairman, distinguished members of the Senate Committee on Veterans' Affairs, ladies and gentlemen, my name is Thomas F. Jones and I am president of the University of South Carolina in Columbia, S.C. I appreciate your giving me the opportunity to appear before you on this occasion to share with you my thoughts and observations on Senate bill S. 2219.

I also want to express my appreciation of the efforts of Senator Strom Thurmond and his office in assisting in arranging for me to be here, and to Representative William Jennings Bryan Dorn, secretary of the South Carolina delegation, for his sponsorship of House Joint Resolution 748, which has similar objectives to S. 2219.

Allow me to take a few moments to acquaint you with the University of South Carolina. The Columbia campus enrolls 14,500 students. Seven branch campuses spread over the State enroll another 3,500 students. The Columbia campus is comprised of 11 colleges and professional schools, including the following health-related divisions: The college of nursing, the college of pharmacy, the school of social work, the department of biology, the department of chemistry, and the department of psychology. Last year we awarded 1,794 bachelor's degrees, 413 master's degrees, 155 juris doctor's degrees, and 81 doctor of philosophy degrees. We are an institution filled with enthusiasm for service to our State.

You will note, however, among those colleges and schools I mentioned there was no college of medicine.

Senate bill S. 2219 takes due note of the shortage of doctors in our Nation. Let me comment briefly on the situation in South Carolina.

Here I will depart to add a few items of statistical data. The mass of statistical data indicates clearly that the health of the people of South Carolina is far below an attainable level. South Carolina ranks 50th in the Nation in life expectancy of its citizens.

South Carolina ranks 49th in the Nation in infant mortality rate, 47th in the Nation in doctor-patient ratio with only 81 physicians per 100,000 population. It ranks 45th in the Nation in its material mortality rate. In fact, South Carolina would require 1,600 additional physicians to bring it up to the national average doctor-patient ratio, which in itself is not nearly enough.

Now I mentioned that South Carolina has only 81 doctors per 100,000 against the national average of over 140. There are only 62 doctors per 100,000 in private practice in South Carolina, which means that medical attention by an M.D. is limited to an average of 1.25 hours per person per year.

Just last week I asked a Columbia physician to assist the university in finding an additional part-time doctor for the university infirmary. I suggested that a young doctor might be given a retainer by the university for half-time services while he built a personal practice.

My friend replied that it only required 2 weeks for a new young doctor to be fully employed in private practice in Columbia, and the Columbia area has approximately the national average of 145 doctors per 100,000 population.

Let me give you another example. Last spring Mrs. Jones and I spent 3 days near Greensboro, N.C. (where there are 140 doctors per 100,000 population for the area, the national average), at the Atlantic Coast Conference basketball tournament. Because we had time on our hands in the mornings we decided to seek medical consultation there on a minor but distressing medical problem. The appointment secretaries of the first two doctors called said that the doctors were taking no new patients. The third offered an appointment 6 weeks in the future. I continued the calls through the entire list of general practitioners and appropriate specialists out of my personal interest in the availability, or unavailability, of heavy care. Most of the 20 or so physicians called were not accepting new patients. The remainder offered possible appointments at delays of 3 weeks to 3 months.

Let me assure you that my apparent rebuff was in no way related to our strong athletic rivalry with North Carolina universities. At no time did I identify myself. I was just a literate person, asking for medical attention, and there seemed to be no help available to John Doe other than at hospital emergency rooms.

I am glad, Mr. Chairman, that our Nation has adopted the national policy that health care should be available to all people regardless of economic status. On the other hand, we all know that the possibilities of living up to that policy are grim indeed without a dramatic increase in the production of doctors.

For some 3 years I have felt great concern over this enormous gap between national policy and reality and I have not held out much hope for closing the gap.

I am happy to say that three things have happened recently which greatly brighten my view of the prospects. House Joint Resolution 748 is one of these happenings and S. 2219 is another. I will speak more on these later. The other happened last Thursday. Let me share the experience with you.

On Thursday last the University of South Carolina arranged for 65 South Carolinians to charter a jet from Columbia to Shreveport, La., over a thousand miles away. Our entourage included educators, doctors, legislators, press, TV, and other community leaders. We spent the day learning how Louisiana State University, the Veterans' Administration, and community leaders had worked together in bringing into being a new medical school in Shreveport in a very short time and at a very modest expense to the State.

Space for the medical school was provided by renovating a number of floor kitchens, nooks and corners, and other spaces in the VA hospital. Costs of conversion were shared in a cooperative and realistic way by LSU and the VA. In addition the VA hospital is used by the school as a major clinical facility along with the Confederate Memorial Medical Center, a State facility some 4 miles away. The staff of both hospitals share in the teaching function along with other qualified doctors from the community. Since the number of full-time teaching staff is small, the instructional budget is much lower than one might expect of a medical school. The thought was expressed more than once by leaders of the school that the overall quality of instruction was superior to that of many medical schools because the teachers had made their primary commitments to practice as contrasted to research and/or administration.

In 2 years the LSU medical school at Shreveport expects to be in its own fine new $30.5 million building for which the Federal Government provided $20 million. When the new facility opens the entering class size will have increased from the present 32 to 100. The annual State appropriation presently is about $2.8 million. When the enrollment in all four classes reaches about 400, the funding will be about $6 million, which is one-half to one-quarter what one normally expects for a medical school budget. This relatively modest cost results from two economic features of the school, the predominant use of part-time faculty and the use of existing hospitals for the clinical program—the VA hospital and the Confederate Memorial Medical Center—instead of centering on a proprietary teaching hospital administered by the medical school.

We were impressed and greatly encouraged by three things which we learned in Shreveport:

(1) A good medical school can be launched in 2 to 3 years, instead of the 5 years of planning which has characterized the past.

(2) Support of facilities shared by the Government, full cooperation of the VA hospital and other community facilities, the involvement of a large corps of qualified doctors, and the enthusiastic backing of the whole community insured rapid evolvement of a quality education program at minimum cost.

(3) Everyone gained from the establishment of the school—the VA hospital, the Confederate Memorial Medical Center, the local physicians, the public of the area, and indeed the entire State, because health service is dramatically improving, from greater involvement

of physicians in medicine through teaching and seminars during the start-up period, and will improve further from increasing accessibility to health care when the graduates begin to emerge 2 years hence.

I can't let this moment pass without noting the great leadership which brought the Shreveport medical school into being. Dean Edgar Hull and Associate Dean George Meneely have done an outstanding job of achieving quality education in a minimum of time, and they have been strongly lead and backed by Chancellor William Stewart, former Surgeon General of the United States, and President John Hunter of LSU.

The delegation of 65 from South Carolina came home on last Friday, June 30, with great enthusiasm for what they had seen and heard in Shreveport. With the possible exception of a half dozen people who had reservations for one reason or another, the entire group felt that a new medical school for South Carolina, modeled after the Shreveport accomplishment, should be sought as a part of the University of South Carolina in Columbia, and at the earliest possible moment because of the intensity and urgency of unmet health care needs in South Carolina.

Senate bill S. 2219, with its several provisions for cooperation between the VA and medical schools, especially in renovating, refurbishing, and providing facilities at nominal cost, providing for cooperation in education and training, and providing for sharing operating costs over the first 6 years of operation, promises to put our rather poor State in a new and positive position with regard to a second medical school. When this bill is enacted into law, our State will have to conclude that it cannot afford not to have a new medical school.

Let me depart from my text to say as regards your formula grants I notice that there are some several in the several bills and resolutions which are all fine and acceptable possibilities. Some provide more money than others, and as a university president I would favor the bill which provides the best start which in this case is S. 2219. I want to say though that the U.S. Government and the VA will get in return services and quality in proportion to what it spends. I also want to note, and I think this is most important, that the bills as written don't propose that this spending be a continuing thing forever. A 6-year program is proposed and the costs that are involved are non-recurrent to the Federal Government beyond that 6 years but the benefits will go on and on into the indefinite future.

I think this is very important, for in the long run the actual expenditure will have been rather small indeed compared to the receiving benefits. In other words, a relatively small amount of seed money will bring into being the kind of capability in medical care that we have really committed ourselves to in this country but have not yet adequately funded.

As we look at the future requirements for health care in South Carolina, it is clear that we need both to expand the existing medical university in Charleston and to establish without further delay a second medical school in Columbia as recommended clearly by Dr. Vernon Lippard, dean emeritus of the Yale Medical School, in his report to the South Carolina Higher Education Commission in 1967. With the help of S. 2219 we can yet achieve his urgent recommendation of admitting the first class on or before 1975, and this we in South Carolina are going to do hopefully, sir, with the help of S. 2219 or its derivatives.

I thank you very much for the opportunity to appear before you today and to tell our story and to say to you full speed ahead. The work that you are doing is most important to the future health of our Nation.

Thank you, sir.

Senator Cranston. Thank you very much, Dr. Jones. Your testimony is most helpful. I am delighted at the very strong position you take in support of this assistance to the States and communities and to the medical students and the universities through S. 2219. I am delighted with your feeling that your State could take over and carry on the program so it would not be of short duration if we start it off with the initial Federal investment that we are talking about.

Dr. Jones. Let me interject here that one of the great hopes of what we saw in Louisiana is this possibility of a start-up at a modest cost, the phasing out of Federal help and then the continuing operation at a very modest budget through improvisation and drawing on community strength.

Senator Cranston. Dr. Wells spoke this morning very favorably of the Shreveport experiences setting the goal for others to follow. Incidentally, despite those unhappy statistics about South Carolina, South Carolina is certainly well represented in the Senate in the effort to provide Federal assistance to do better. Senator Thurmond has been involved, and he would be present today except for his having to be in the hospital today. Also, William Jennings Bryan Dorn has been very helpful in the House.

I am very grateful to you for coming. Thank you.

Dr. Jones. Thank you.

(The prepared statement of Dr. Jones follows:)

STATEMENT OF THOMAS F. JONES, PRESIDENT, UNIVERSITY OF SOUTH CAROLINA

Mr. Chairman, distinguished members of the Senate Committee on Veterans Affairs, ladies and gentlemen:

My name is Thomas F. Jones, and I am President of the University of South Carolina in Columbia, South Carolina. I appreciate your giving me the opportunity to appear before you on this occasion to share with you my thoughts and observations on Senate Bill S2219. I also want to express my appreciation of the efforts of Senator Strom Thurmond and his office in assisting in arranging for me to be here, and to Representative William Jennings Bryan Dorn, Secretary of the South Carolina delegation, for his sponsorship of House Joint Resolution HJR 748 which has similar objectives to S2219.

Allow me to take a few moments to acquaint you with the University of South Carolina. The Columbia Campus enrolls 14,500 students. Seven Branch campuses spread over the state enroll another 3,500 students. The Columbia campus is comprised of 11 colleges and Professional Schools, including the following Health-related Divisions: the College of Nursing, the College of Pharmacy, the School of Social Work, the Department of Biology, the Department of Chemistry, and the Department of Psychology. Last year we awarded 1,794 Bachelors degrees, 413 Masters degrees, 155 Juris Doctors degrees and 81 Doctor of Philosophy degrees. We are an institution filled with enthusiasm for service to our State.

Senate Bill S2219 takes due note of the shortage of doctors in our nation. Let me comment briefly on the situation in South Carolina. South Carolina has only 81 doctors per 100,000 against the national average of over 140. There are only 62 doctors per 100,000 in private practice in South Carolina which means that medical attention by an M.D. is limited to an average of 1¼ hours per person per year.

Just last week I asked a Columbia physician to assist the University in finding an additional part time doctor for the University infirmary. I suggested that a young doctor might be given a retainer by the University for half time services while he built a personal practice. My friend replied that it only required two weeks for a new young doctor to be fully employed in private practice in Columbia—and the Columbia area has approximately the national average of 145 doctors per 100,000 population!

Let me give you another example. Last spring Mrs. Jones and I spent three days near Greensboro, North Carolina (approximately 140 doctors per 100,000 population for the area—the national average) at the Atlantic Coast Conference Basketball Tournament. Because we had time on our hands in the mornings we decided to seek medical consultation there on a minor but distressing medical problem. The appointment secretaries of the first two doctors called said that the doctors were taking no new patients. The third offered an appointment six weeks in the future. I continued the calls through the entire list of general practitioners and appropriate specialists out of my personal interest in the availability, or unavailability of health care. Most of the 20 or so physicians called were not accepting new patients. The remainder offered possible appointments at delays of three weeks to three months.

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Thank you for your attention.

Senator CRANSTON. The next witness is Dr. David D. Rutstein, Ridley Watts professor of preventive medicine at Harvard Medical School, Boston, Mass.

Doctor, we are delighted to have you with us.

STATEMENT OF DAVID D. RUTSTEIN, M.D., RIDLEY WATTS PROFESSOR OF PREVENTIVE MEDICINE AT HARVARD MEDICAL SCHOOL, BOSTON, MASS.

Dr. RUTSTEIN. Thank you very much, Senator, for this opportunity.

Senator CRANSTON. You have been involved with the VA yourself.

Dr. RUTSTEIN. I am a member of the special medical advisory group of the Veterans' Administration.

I might say just to give you some background on myself so that you can weigh my testimony, so to speak, I am a qualified internist and cardiologist so I know something about the practice of medicine. I have been deputy health commissioner of New York City and director of health facilities under Mayor La Guardia so I have had some experience on the administrative side. I am associated with the Veterans' Administration. I teach preventive medicine to medical students and have been concerned with the planning of a blueprint of medical care for the United States, some of which has been published by the MIT Press in 1967 in a book entitled "The Coming Revolution in Medicine," and last year was involved in the role of technology in all of this in the book called "Engineering and Living Systems." I am presently chairman of the subcommittee for the National Academy of Engineering trying to find out how NASA technology can be adapted to civilian medical care.

I am sorry, Senator, that in the short time available I did not have a chance to prepare my testimony in writing but I have given your assistant a copy of three charts. I use these charts because I believe that the Veterans' Administration with its 120,000 some beds represents a system of medical care whereas our entire country practices medical care without much system.

I think we would all agree, although we cannot know exactly the form it will take, that we will have a national program of medical care of some sort. I wanted to testify today because I believe that the Veterans' Administration and some of the provisions in the bill which you have before you for modifications in the function of the Veterans' Administration in terms of its medical care can provide a great deal of leadership because indeed they have a system and the system works.

Now the provisions in one of your bills for extending the scope of care among veterans makes it possible for the future to look at medical care beyond the walls of the hospital. You see, one of the curses of medical care in the United States is that we have gotten to believe that you can only treat patients in the horizontal position when they are lying in bed. This is the most expensive way to treat patients. We have not paid much attention to any systematic way of treating patients in the vertical position on the hoof. This is a much cheaper way of providing medical care and in many instances as good or better medical care. There are reasons for this.

One of the major reasons is that with our present voluntary system of medical insurance it is impossible to set up any kind of prediction of cost of ambulatory medical care as long as services are paid for one at a time and as long as physicians are able to prescribe as many services as they wish. No actuary can give you any idea what the premium should be. Therefore, when Blue Cross or Blue Shield says, "We will pay for this expensive task," they usually say, "Yes, but you must be lying horizontal first in a hospital because we can control that because we know how many beds there are."

But by this same token I would estimate somewhere between 20 and 25 percent of our hospital beds at the moment are unnecessary hospital beds, particularly in our larger cities, and I speak specifically about Boston. A lot of the patients in these beds don't have to be in bed at all, and one way of cutting down the inefficiency of the present lack of system would be to have better ambulatory medical care.

Senator **Cranston**. How will the problem of the actuarial difficulties be gotten-around?

Dr. **Rutstein**. I think, sir, the only way the actuarial difficulty can be gotten around is if you can do what the Kaiser-Permanente system does. I don't recommend the Kaiser-Permanente system as a system for the country but they have done one thing. They have been able to run their hospitals at a profit and they presumably are providing good medical care although I have seen no particular analyses of their health indices but I have heard—at least I would guess—that their care is as good certainly as the casual care you would get around the country.

Now what they have done is as follows. They control three things. They control the hospital system, they control the insurance company. In terms of your question they can predict in any 1 year what their total professional costs will be. The way they do this, they make a contract with all of the doctors who work in their system and they say to the group, which is a separate corporation, we will give you X million dollars next year for providing all of the professional services; you may divide this any way you wish but we will build in special incentives.

If last year 80 percent of gastrointestinal examinations were provided in patients in the horizontal position, for every 1 percent that you can change out of bed into the vertical position we will increase our contract with you. So they have built into their contract incentives to keep patients out of beds. They also have a predictable amount that they pay for their professional costs so the actuaries can sit down and say, Well, we have this much money to deal with, you see, and they can predict then how to share the cost. You cannot do this with a complete nonsystem of medical care on a completely fee-for-service basis.

Does that answer your question, Senator?

Senator CRANSTON. Yes.

Dr. RUTSTEIN. Now going on, there is another point which is of some importance and that is that our hospitals tend to be self-centered rather than community centered, and this grows out of a very proud tradition. Every hospital wants to do the best it can; it wants to have every piece of equipment, it wants to have that open heart surgical unit, it wants to have that cobalt. The result of this is that since every hospital is self-centered rather than community centered we have endless duplication of these facilities, far more than we need.

We have far too large a capital investment in a lot of this, and not only more capital investment but we also have far too great a cost of operating these facilities, but this is the least of it. This is the least of it, sir, because when you have a community hospital with all of the pride of the trustees, all of the prestige of the staff, all of the drive of the financial supporters that will pay for this so that they now can point to their unit, you cannot get very good medical care if you are the one person that was in there once every 2 weeks for your open heart surgical operation.

They don't have enough experience, and as a matter of fact there are recent data collected in New England that shows that the fatality rate by case of surgical operations on the kind of heart disease that babies are born with, congenital heart disease, is about half for each individual kind in the Children's Hospital of Boston than it is in the community hospitals of New England. So it is not only a question of wasting money, it is also a question of not being able to provide as good medical care as you would like.

So we then have a question if every hospital cannot do everything, then how can we possibly get all medical care for everybody? What we need are regional systems of care, and in this the Veterans' Administration is providing leadership; they have set up regional systems of their own hospitals with a central hospital that provides the super specialty services and the peripheral hospitals that provide more of the personal services and the common variety of surgery-medical care and the usual sort of care. It makes up 90 percent of all medical care.

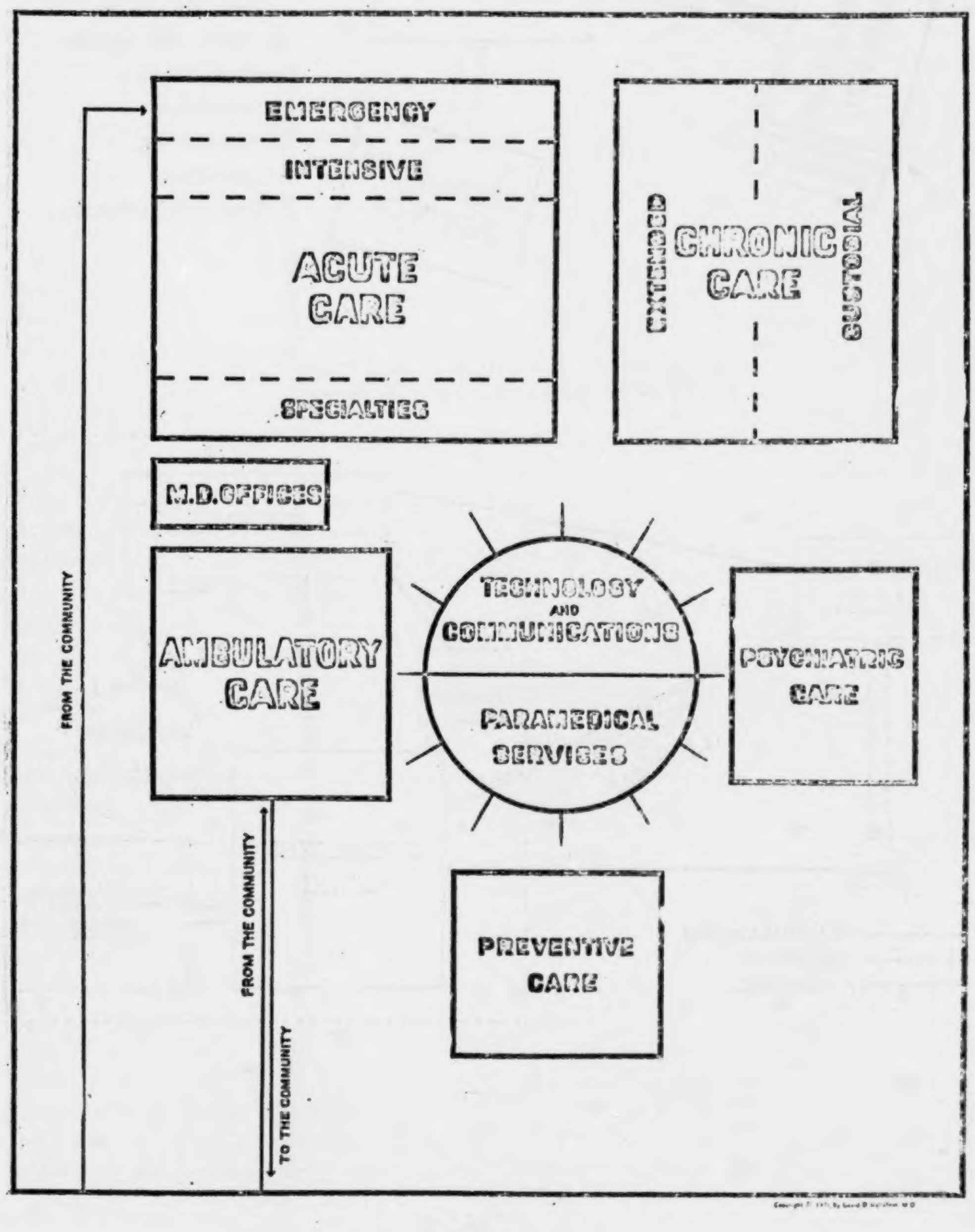
Now I see that you are providing in one of your bills for the building of medical schools affiliated with these various veterans hospitals. Let us back away from the problem and look at the perspective on all of this. On the second chart that you have there there is a design of the regional medical system of the Federal hospital.

Senator CRANSTON. Incidentally, I want it to be understood that the charts will be in the record.

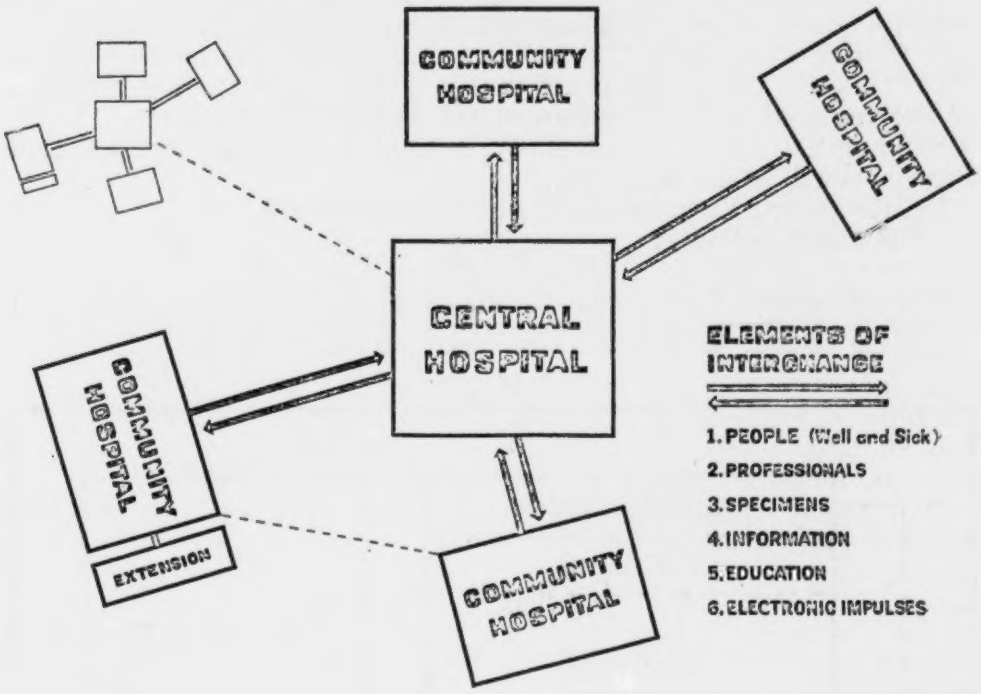
Dr. RUTSTEIN. Yes; the charts will be in the record.

(The charts follow):

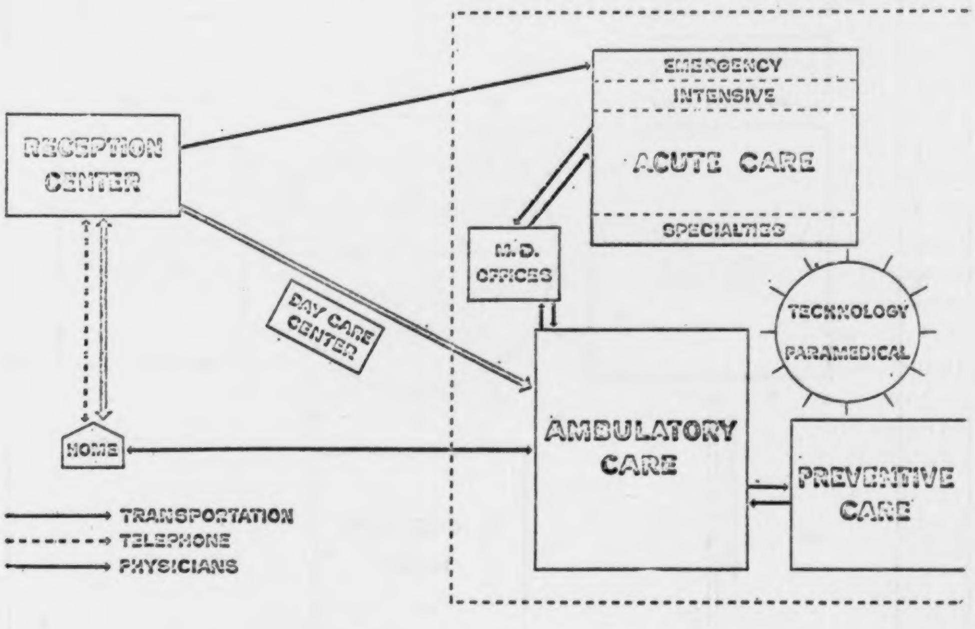
THE HOSPITAL OF THE FUTURE



REGIONAL SYSTEM



AMBULATORY CARE



Dr. **Rutstein.** In the second of those charts you will see there is a central hospital and then there is a surrounding group of community hospitals with the specialties to be concentrated at the heart of the region.

Now I would view the region as covering 1 to 3 million people as that is my vision of the size of a region. If you do this and if you examine the distribution of medical school teaching hospitals in the United States, you will find that in most of our country you could have as the heart of an individual region a teaching hospital but there are places where no medical schools now exist. Some of them are listed in your bill providing for the building of medical schools in some of these areas.

Now several things occur to me. First, after World War II the creation of the dean's committees which tied the major veterans hospitals to medical schools and made teaching hospitals out of them built up the standards of those hospitals to the standard of the average medical school teaching hospitals. You have two such veterans hospitals affiliated with the Harvard Medical School and we use them as teaching hospitals for our students and for our graduates.

Now there are, however, hospitals in other areas that are not quite up to that standard because there are no medical schools there. Now it is a happy coincidence that the location of these particular veterans hospitals where there are now no medical schools are also the locations of the places that you would visualize to be the central hospitals for regions if we set up a system of regional medical care in the United States. So you would be building up the strength of these hospitals, you would be putting a medical school there, but you would also be strengthening the medical care for the entire region by providing a point of concentration of the super specialty services.

Senator **Cranston.** Would you submit for the record which areas you are talking about in particular?

Dr. **Rutstein.** Well, you already have some of them listed. One of them is Temple, Tex., I believe. One of them I think was in South Carolina. You have them listed. If you look at most of those, you will find there is no medical school in those areas. As a matter of fact, there is an official document on this cause submitted to us as a member of the special medical advisory group of the Veterans' Administration. Several years ago we had a meeting with the Government representatives of the regional medical program for heart, cancer, and stroke and they identified at that time the places in the country where if you set up a regional system such as the heart, cancer, and stroke program you would need medical schools.

Now if we go on from there, if we have a regional system of medical care in the United States, if we have a super specialist group at the center of this to provide the super specialist services, if these all come up to a central point in Washington, we run into another great need and here again the Veterans' Administration hospitals can be helpful.

For example, I will refer to the bill called I guess S. 3. I am not supporting S. 3 but at least it provides a structure upon which I could now build something which might indicate the kind of thing I am talking about in terms of standards, indexes and so on of medical care in the United States. If you have theoretically a structure of whatever this board would be of six people responsible to some Secretary, in this case HEW, which does not exist in S. 3, you should have a strong professional advisory group that would have about four responsibilities:

1. To establish standards;
2. To establish indexes of health;
3. To establish priorities in terms of where the best places would be to spend the limited amount of money and use of limited resources; and
4. To serve as a relay point for similar committees at the regional levels so you would evaluate the quality of medical care in the regions and you could get feedback from the regional areas to point out to the national group that their standards are not what they should be because they don't fit the real situation at the grassroots level.

Now what do I mean by standards? Well, it is a funny thing, you know Washington when they want to buy anything in the Government, if they want to buy a piece of lead pipe, they specify how long it will be, how thick the walls are, what the end result will be, but for medical care you don't specify anything and it is time you did because you should. All through medicare and medicaid—I saw the headlines this morning, I believe, in the New York Times something about 25 percent of the medicaid services are unsatisfactory. These are just ad hoc decisions; there are no standards set up to determine this.

The same thing is true of medicare. There have been no standards set up for any of these even existing programs, and these standards would be important for indexes. Now what do I mean by indexes of health? I think the time has come when you can measure whether or not medical care in a particular area is good or not good. Sure, you use life expectancy and infant mortality and things that have been used in the past and they are useful but there are more simple things that could be used.

Nobody should die of diphtheria in the United States; nobody should have measles in the United States. The death rate of cancer in the cervix in women ought to be practically zero. The death rate of cancer ought to be small, certainly less than 20 percent. In other words, you would take the various diseases and by looking at an area decide what the standards of care were.

Let's look at the State of Texas in this point of view right now. The State of Texas has, I think, the best known heart transplant unit in the country in Houston—or say one of the two. You have one in California, too, I understand, at Stanford but I might say we have none in Boston. In this new relatively gimmicky area there is lots of money spent and lots of interest, but at the same time in Texas this last year one of the biggest epidemics in the last few years still occurring in San Antonio; there have been thousands of cases of measles in that State even though we have an efficient vaccine.

Now I picked Texas, not to be nasty about Texas, because there is a town called Texarkana and that set up an interesting natural experiment. Texarkana as you probably know strides the boundary between Arkansas and Texas so half the town is in Arkansas and half is in Texas. They had an epidemic of measles in Texarkana this last winter of 500 some cases. You know, it was interesting only 16 of those cases were in the State of Arkansas.

Arkansas has a good program for immunization against measles and Texas has the program limited to the private practitioners of Texas so that large population groups don't get covered. I just give you these things to show the kind of indexes that can be used to determine the kind of health services that are provided in various parts of our country so that this group could set up some indexes.

Now with these indexes of health and with these standards you could protect doctors against being sued for malpractice. If it could be demonstrated that they met these standards and maintained good health indexes, the doctor could be protected against suit. So there would be another advantage, there would be a third advantage. If we ever get to the point where doctors are going to be part of a national health system, the method of payment of doctors will be terribly important.

Now I really believe there have to be incentives for doctors and payment to doctors because you are asking somebody to be up 24 hours a day, you are asking them to do something else. The fee for service method has not worked very well and it is out of control as far as ambulatory care insurance is concerned, as I have already told you. So one might start by setting up a modified program of fee for service within certain limitations but I would build into any system of payments incentives so the doctor would get paid more if he were in a community that had better indexes of health, practicing better medical care for a community. The Kaiser-Permanente has built it in. I think you would build in incentives that would make the service cheaper and better and at the same time protect the doctor against being sued for malpractice if he did a good job.

Third, we talked about standards. In terms of priorities I think we have to face the fact with payment for medical care already at 7 percent of GNP and going up all the time that some way there must be a ceiling some place here. There are certain kinds of care that we already see we cannot provide complete. We are going to have to have some priorities about what we can afford to pay for and what we cannot afford to pay for.

I happen to be one of the few people in this country who believe we are living beyond our means in many ways. I am afraid some of this is hitting medical care, too. If I have a choice between paying for decreasing infant mortality or transplanting a heart in a man 85 years old, there is no question about where I would spend the money.

With lack of priorities in the past a lot of money has been spent on the things that are really less useful. I don't mean to be disrespectful, Senator, but it has been said that the reason we concentrate on heart, cancer, and stroke is because the babies don't vote. We are interested in diseases of old age somehow rather than the diseases of young people and this does not make very much sense really in terms of the health of the country, the workers, the people who are actively contributing to our country.

I hesitate as a doctor to think of those long lines of people lining up in front of hospitals waiting to have their worn out organs replaced. This does not look very much like a good health or medical care program for the United States. I think we ought to be concentrating at quite a different area. I am happy that the Government has just voted a bill for cancer control and we want to spend money on that, but I think it is completely out of perspective to the health of the country.

Senator **Cranston**. Doctor, could I ask if there are any specific weaknesses or oversights in the bills we are considering? The reason I ask on that point specifically is I have a dilemma between spending time here and not spending time in the conference.

Dr. **Rutstein**. I will make a few specific recommendations. I would like to suggest first that in any plan for the future using the leadership that you developed here to extend the care for the individual veteran that you try to get more complete care rather than hospital care because it will be cheaper and better, you can treat the early stages of disease in their preventive stages. I am interested in preventive medicine. Certainly I would recommend following out that procedure and extending the care from just having a hospital where somebody who has not been handled by the regular medical system finally is placed. I think you need continuous medical care and I think in this day and age we have to have care all the time. So this is one recommendation.

As far as using the Veterans' Administration as an educational system, I have already spoken about the medical schools. I think it is very important that we build on the allied health professions. I think the Veterans' Administration if you do this for them can do something else which they have already started to do. They are already starting the study to determine what tasks are being performed beginning with the doctors day by day to ask the question, "Which of these tasks require the knowledge, background, education, and experience of the doctor and which don't, and among those which don't which could be transferred to an allied health profession, to a machine or to both?" So your bill recommending the allied health education is in line with this.

There is another strength in that bill which I think we may not know about and that is most of the education of the allied health professions vis-a-vis medical education has been quite separate. The doctors are educated in the medical schools, the others some place else. There are places where they fit them together. Some of us naively believe that if you want to have a team work together to take care of patients in the hospital you ought to educate the team together while they are being trained together and the Veterans' Administration would be a beautiful place to do that with the medical schools. So this is another plus I think for the legislation group that you are supporting.

I would hope you would go one step further with that. If you look at the education of the medical student and the education of the allied health professionals and look at these professions individually, you will find that the borders of these professions have not been defined very clearly, so what you have is a patchwork quilt so that some of the patches are over on top of each other where they duplicate each other and there are holes in between, and now we have tried to put a big patch over it without defining it.

I think the VA could do that for you with their schools of allied health professions. All we have are licensure laws, and licenses don't qualify anybody to do anything, they just identify the class. I am licensed to practice in New York and Massachusetts, I am licensed to do brain surgery and I am licensed to do chest surgery, I am licensed to do psychiatry because I am permitted to do anything a doctor can do, but I am not licensed by science.

The VA bill could do this and could define the areas by doing nothing except making the curriculums fit together and make the pieces work together more efficiently, and they have a place to test it right in the Veterans' Administration hospital. Nobody has that facility in the country so the VA again could do that particular job.

I think that is about all I want to say, Senator, unless you have some questions.

Senator Cranston. We will submit the transcript back to you for any corrections you want to make.

I am very late and I want to apologize for hurrying you along. If I am not at that Health Manpower Legislation Conference, I won't be able to do what I want to help the medical schools get the basic money they need.

Dr. Rutstein. Thank you.

Senator Cranston. Thank you very much.

The next witness is Dr. John Grupenhoff, executive secretary, National Committee To Save Our Schools of Health.

Doctor, we deeply appreciate your being here. I hope you can do as I have suggested with the other gentlemen, submit your prepared text for the record and summarize briefly.

STATEMENT OF JOHN GRUPENHOFF, PH. D., EXECUTIVE SECRETARY, NATIONAL COMMITTEE TO SAVE OUR SCHOOLS OF HEALTH

Dr. Grupenhoff. Senator Cranston, I appreciate very much the help of Jon Steinberg both on this bill and the health and manpower bill that you are going into conference on this afternoon. In 1968 it was my pleasure to participate in the administration's setting up of the Health Manpower Act and to work in developing our procedures to see that it got to the Congress from the administration side. This year, of course, the appropriations for health manpower must be dealt with, as well as the authorized legislation. We formed the National Committee To Save Our Schools of Health. I would ask you to take note of the fact that Dr. Clark Kerr, of California, and Dr. Joshua Lederberg are also members of that committee. You should note that Phil Lee, who participated in the hearings this morning is also a member of that committee. All three are distinguished Californians.

On the House side we testified that we would be pleased to see two things included in the VA bill; one, that the bill be expanded to all the health professions, which was done and for which we are appreciative. The second thing we indicated was that we were very concerned that the Secretary of HEW be instructed in the bill to have as much cooperation as possible with the VA so that there were not overlappings and difficulties between the agencies, and this you have done in the bill

We strongly support the bill, and we appreciate the work that you have done. One comment about the need for the bill, and what it could do, I would like to make very quickly. I was Deputy Assistant Secretary in HEW in 1968 and I saw how difficult it was to pull things together from all the viewpoints of the HEW personnel and all the agencies. I was present when Senator Hill proposed an Under Secretary of Health for HEW, to pull together all of the agency programs in health.

Also in 1969 I headed up all the field offices of HEW and at that time we were able to establish in the field offices of HEW a Deputy Regional Director for Health Affairs. This man's job was to pull together all the health programs at the regional level for HEW. I would urge that perhaps in report language there could be a statement urging that that regional official who has just now come into being and will have the responsibility for pulling together the regional affairs be directed to work with the regional directors in VA offices as well in the field of health to assume success of this bill.

(The prepared statement of Mr. Grupenhoff follows:)

STATEMENT OF JOHN T. GRUPENHOFF, PH. D., EXECUTIVE SECRETARY, NATIONAL COMMITTEE TO SAVE OUR SCHOOLS OF HEALTH

Mr. Chairman and members of the subcommittee, I appreciate the opportunity to testify before your Subcommittee on S. 2219. I am indebted to your staff for the courtesies they have extended to me and to Dr. Arthur M. Sackler, Chairman of the National Committee to Save Our Schools of Health.

The Health Manpower crisis is a real one: we are seriously short of manpower; what we do have is maldistributed; and the schools which create the manpower pool are in deep financial trouble.

Our Committee was therefore established early this year because many public-spirited leaders recognized that 1971 is crucial in many ways to the future of the health care system of this Nation: the Health Manpower Act of 1968 is up for renewal, and will set the outlines of policy for several years to come, and the HEW appropriations bill will determine levels of funding for the next year. There is the possibility of passage of a National Health Insurance Bill of some kind within the next several years, and heatlh manpower policy must be set to meet the demand that Act will create.

I am aware, Mr. Chairman, that you serve on the Committee which heard testimony and reported out the Health Manpower Act of 1971, so that you know full well the seriousness of the crisis. Most of those who testified before the Committee on Labor and Public Welfare were health professionals. However, the National Committee to Save Our Schools of Health, which is still in formation, and of which I am Executive Secretary, is made up of laymen and experts who are deeply concerned, and who are advised by an excellent group of health professionals. At the end of my statement, you will find a listing of these committee members, as well as a background document explaining our views on the crisis. I hope you will agree that they should become part of the Record.

Mr. Chairman, last year our Chairman was named by the Director General of the World Health Organization to be Chairman of an International Task Force on World Health Manpower, which was created to study the manpower problems, and to recommend those innovative programs for training manpower already in existence for use elsewhere in the world. In his travels to over 20 countries he was led to this conclusion: everywhere there is a shortage of health workers; everywhere schools of health have financial problems; everywhere public demand for better health programs is increasing; everywhere, but especially in underdeveloped countries, the benefits of health research have not yet reached the sick; everywhere pain, discomfort, and grief could be ameliorated by the simple process of educating and organizing more of the proper kinds of health workers.

The United States, in many respects, is no different: though we are a wealthy country, our very wealth exacerbates our health problems. All of us have high expectations for health care, but geographically concentrated wealth causes a maldistribution of health care providers. Further, we have national health care plans—Medicare and Medicaid—which have created further demands upon an already overloaded system. We failed to build into the demand structure an increase in supply of manpower, and the increase in monies with a static manpower supply helped us push costs upward. So, if we are to have some form of National Health Insurance, we must plan now to begin to develop the needed manpower supply. Hopefully, a universal insurance scheme will have built into it an earmarked percentage of funds for the continuous, stable, and predictable support of students and schools to assure that supply.

Mr. Chairman, President Nixon is aware of the enormous potential of the Veterans Administration to help solve this crisis. In his statement of April 2, 1970, on veterans' medical care he said,

"Fuller reliance on the VA's system of 166 hospitals for medical education purposes would not only improve the VA's position—as a consumer of health services personnel—but would also help the entire nation meet its requirements in the health manpower area."

Later, on February 18, 1971, in his message to Congress on Health, the President asked the Administrator of Veterans Affairs and the Secretary of Health, Education, and Welfare to develop ways in which the Veterans Administration medical system can be used to supplement local medical resources in scarcity areas.

I believe S. 2219 is supportive of this thrust. It provides an excellent opportunity to begin moving in the direction of providing more health professions schools rapidly, in areas which do not have such schools, giving support to those schools in such a way that little or no new construction is required immediately, thus allowing the schools to get underway at once. I understand the medical school in Shreveport began in less than 15 months—about ¼ the time a typical new school requires to begin operations. If the ten new schools called for by this Bill can get underway in a similar time, that probably would go a long way toward achieving the goal set by this Administration of 20 new medical schools by the mid 1980's.

During these hearings I am sure that you will hear many things about what is wrong with this proposal, from expressions of concern about the quality of education, to the concern about multiple sources of funding of medical schools, to the insufficiency of certain kinds of faculty, to concern about inadequate facilities. I believe that each of these arguments is open to question. But rather than argue them, it seems to me that we should look at the broader, and much more positive side of the question. We *can* produce hundreds more doctors than we now produce; the Congress *can* enhance efficiency even with multiple support programs. Congress *can* take the one, most extensive system of health care, the largest in the Nation, and have it participate in the production of health manpower, without impairing—rather, at the same time improving—the health care of veterans.

The veterans of this country have a claim upon us for the best medical care that it is possible to deliver to them. Those who have borne the brunt of protecting our Nation's international concerns should not also be asked to bear the burden of inadequate medical care as well. There can be no brinkmanship in regard to this national obligation. We cannot gamble, and at this time we would be gambling on the future availability of health manpower for service to our veterans.

As you know, at this time our Nation relies heavily on foreign medical graduates for care of our citizens. What an inequity it would be if we had to brain-drain other nations, poorer countries, to serve our veterans. What an irony that this rich country would have to be dependent on foreign health care workers to take care of American veterans.

More than half our private medical schools are in deep financial trouble, and even if they were not, they cannot meet present, let alone future, civilian health care requirements.

This Bill should help in the delivery of good care, because it seems to me to be an irrefutable argument that whenever a hospital is closely affiliated with a health professions school, the very requirement for excellence in that school improves the hospital, and both institutions benefit. A study of the 81 schools now affiliated with the VA hospital, I am sure, would bear this out.

Mr. Chairman, we testified in May of this year before the House Veterans' Affairs Committee on a bill similar to S. 2219, House Joint Resolution 464, which has since passed the House in amended form as H.J. Res. 748. At that time we urged the House committee to consider expanding the scope of H.J. Res. 464 to make all accredited health professions schools eligible for aid under that bill, and not just medical schools. I note that your bill, S. 2219, does provide for such expanded eligibility and I commend you for it.

Dr. Marc Musser's testimony this year before the House Interstate and Foreign Commerce Committee indicated the remarkable degree to which the VA is now involved in the training of all kinds of health workers. For example, that 8,649 interns and residents last year received post graduate tutoring at VA hospitals; that all 51 dental schools have affiliations with VA hospitals, and that 20 percent of all post graduate dental training takes place at VA hospitals; that basic nursing students from 22 percent of the Nation's nursing schools are trained in VA hospitals; and 25% of pharmacy interns and residents receive training in VA hospitals.

We not only have a shortage of physicians, which the U.S. Public Health Service last year in Appropriations Hearings indicated is 48,000, we are also short: 17,800 dentists; 150,000 nurses; and 266,000 allied health manpower.

Other authoritative estimates are that we lack 8,700 optometrists, 12,900 podiatrists, 9,300 veterinarians, as well. This massive shortage of health workers is the only major work force shortage this Nation has.

Mr. Chairman and members of the subcommittee, the VA health care system is a prepaid system for veterans in which the prepayment is service in the Armed Forces. Veterans have fulfilled their share. However, their payment so often is more than just service. It also involves injuries and illness, crippling, and increased vulnerability to disease.

Passage of this bill is an important and relatively inexpensive act. It is an act, gentlemen, which can help to show the fulfillment of our Nation's commitment to what I would call a contract of conscience.

The Veterans' Administration facilities were conceived and built to give "tender, loving care", so to speak, as an integral part of good medical service. But we must recognize that these inanimate hospitals and clinics cannot give "tender, loving care". They cannot make diagnoses, they cannot prescribe medicine, and they cannot give treatment without trained and qualified doctors, nurses, paraprofessionals, and other health care workers.

We are short of health manpower now, and this shortage will become even greater as Congress enacts the clearly needed additional civilian health care legislation. But of special interest to this subcommittee, the load of VA patient care will multiply, possibly several fold, as veterans of World War II and Korea come into the high health care age.

Thank you for your attention. I would be pleased to answer any questions you may have.

Senator CRANSTON. That sounds like a very constructive proposal. I do have a few questions that I want to ask you in the remaining time we have.

Could you please outline for the subcommittee your experience in the field of health manpower legislation?

Dr. GRUPENHOFF. No, I think that in the interest of time here, what I have said is sufficient.

Senator CRANSTON. I very much appreciate your support of S. 2219 and we are going to count on you for some further help in dealing with various proposals that are being made in connection with it.

Since you have had considerable association with the Department of Health, Education, and Welfare, I would appreciate your explaining why you do not share the administration's fear about the bifurcation which would occur between HEW and the VA in health manpower training support if S. 2219 were enacted.

Dr. GRUPENHOFF. Senator, this has been the position both in this present administration and the last one, of course. I don't see it that way at all because I believe the only way that you are going to get the kind of cooperation that you want between HEW and the Veterans' Administration is for the Congress to hold their feet to the fire and require that they do get together.

I recall Secretary Gardner saying to Senator Muskie during the time of the 1967 air pollution bill that the Senator should hold Secretary Gardner and the HEW's feet to the fire, so the agency group would work together. I think this bill will do that. I think it is going to require, for the first time, real cooperation between the VA and

HEW and I think you ought to push that part of the bill as hard as you can. That will cause a linkage instead of fractionalization.

Senator CRANSTON. Do you think the HEW will make use of the VA system in health manpower training if we enact S. 2219?

Dr. GRUPENHOFF. Yes; I think they will. I have talked with a number of people out there at the Bureau of Health Manpower of HEW and I think that they anticipate no great problems. I think it can be done and I think as long as the bill language requires cooperation the Secretary and the Administrator must be involved. We must make sure that the grants to the schools of Health Manpower are made with agreement of both the Secretary and the Administrator. If that is done, and regional language requiring a tying together, then I think we will have good cooperation.

Senator CRANSTON. In other words, you think they will do so if not left to their own devices?

Dr. GRUPENHOFF. That is exactly right.

Senator CRANSTON. I fully endorse your stress on the need to begin to develop the manpower immediately as we move toward some kind of national health program. Indeed, this was the motivation for the amendments adopted by the Senate, which I offered to S. 934 and S. 1747, the health professions and nurse education bills now pending in conference with the House.

I thank you very much.

Dr. GRUPENHOFF. Thank you very much.

Senator CRANSTON. Our next witnesses represent the American Association of Junior Colleges: Paul Lowery, superintendent, Des Moines Area Community College, Des Moines, Iowa; and Dean Nancy Hartley, St. Petersburg Junior College, St. Petersburg, Fla.

I am grateful for your presence this afternoon.

I want again to request that you might submit for the record your prepared statement and be somewhat brief now because I want to get to that conference.

STATEMENT OF PAUL LOWERY, SUPERINTENDENT, DES MOINES AREA COMMUNITY COLLEGE, DES MOINES, IOWA; ACCOMPANIED BY NANCY HARTLEY, DEAN OF INSTRUCTION, HEALTH RELATED PROGRAMS, ST. PETERSBURG JUNIOR COLLEGE, ST. PETERSBURG, FLA.

Mr. LOWERY. Thank you very much.

I am Paul Lowery, president of a community college and I am here today on behalf of the American Association of Colleges to speak in favor of Senate 2219.

Accompanying me is Dean Nancy Hartley, specialist for health related programs in St. Petersburg Junior College, St. Petersburg, Fla.

My statements are in support of S. 2219 from the viewpoint of the president of the community college, and Mrs. Hartley will speak from the viewpoint of a specialist in the health and related educational fields.

It is certainly a pleasure to be in league with my own Senator, Senator Hughes, who is a member of this committee.

Senate bill 2219 is intended to meet the Nation's very urgent need for health trained personnel at all levels. We on the junior college level would certainly like to encourage and emphasize the place of the junior college in providing education for the allied health areas, the area below that of the professions. This bill was also intended to help create new institutions for health education and training and to expand existing institutions such as the 2 year, post-high-school institutions and the 4-year colleges.

The American Association of Junior Colleges is in complete agreement with the purposes of this legislation, and at this particular time there are approximately 1,100 2-year junior colleges located throughout the Nation enrolling two and a half million students.

These junior colleges already offer health-related programs to many thousands of students. There are approximately 350 nursing programs at junior colleges, and in many States the hospital diploma schools are being phased out in favor of 2-year nursing programs at junior colleges.

There are an estimated 1,400 allied health programs at the junior college level leading to an associate in arts degree in programs in many of the allied health occupational areas. There are some 600 other programs less than 2 years in length providing persons in the paramedical areas of practical nursing and giving assistance in many other areas as well.

Certainly the junior colleges are wholeheartedly in support of the new careers or human services approach which emphasizes programs in which the relatively unskilled can take courses part time to upgrade themselves, both economically and professionally. It is possible, for example, for a low-skill hospital employee who has not completed high school to take evening or part-time courses to pass a high school equivalency examination, then take courses to become a nurse's aide or assistant, continue to work, and perhaps in time become a nurse.

In my own institution, for example, in our fourth year we enrolled approximately 2,400 individuals in allied health program; more than 300 of these were full-time health or allied health areas and more than a thousand were in part-time programs, many persons who were employed in health-related areas. Their purpose in attending school was to upgrade themselves or perhaps to change occupations to another or a higher level within the allied health area.

Also at my own institution and in the State of Iowa, and I think generally throughout the community colleges in the Nation, students with experience in the health allied occupations have an opportunity to test out or challenge any course that is offered. This is of particular interest to the veterans as well as others who for various reasons delayed their formal education. This procedure gives them an opportunity to get into the program and test out of basic areas that they have had experience in, permitting them to complete the program well ahead of the scheduled time.

Junior colleges across the country do welcome the opportunity to work cooperatively with the VA. At the present time about 84 community colleges across the country do cooperate with VA hospitals on a contractual basis, either "within hospital" courses or hospitals located at the various campuses adjacent to the VA hospitals. In my own particular community college district in Iowa we have two VA hospitals. These hospitals make their facilities available to the community colleges adjacent to their facility.

S. 2219 of course is an especially good piece of legislation in terms of the Nation's needs and also in terms of supplying the needs of returning veterans for opportunities to get into full-time employment upon returning. It will provide $125 million a year for health education and training and will make substantial sums available for the expansion of present health nursing and allied health education programs as well as for the establishment and expansion of existing educational facilities.

The act itself lists the tremendous need across the country but it is also projected by 1975 that 5 million persons will be employed in the health services area. Our particular State of Iowa I think ranks No. 2 in terms of the persons over 65. These persons require extensive health services in proportion to the general population.

In closing I would like to mention two or three areas in which junior colleges have a great interest and in which I feel we have a great capacity and capability to make a positive contribution to providing allied health personnel. The 2-year colleges are not concerned with rigid entrance requirements as the universities are; therefore, we are not too concerned with the prior education background of the student so we are able to offer programs to those who have little formal education and enable them to advance to the greater skilled levels.

We certainly want to provide programs for the returning veterans but not limit the programs to these. The Dallas County Junior College in Texas, for example, has had a grant recently from the Public Health Service for a program to train returning medics in these fields. We hope that this program can serve as a model for similar efforts in other States that would encourage the Federal Government to invest more funds to provide additional needed educational programs.

It is my feeling that the community colleges are in a unique position to expand their offerings at very little cost to provide the services needed for the allied professional areas. We have the system, we have the mechanics, and in most cases there is a college close to the VA installation. At present the Staten Island Community College in New York City is working with the Bronx VA Hospital to set up programs. We would like to recommend that high priority be given to contractual arrangements with the existing community colleges within the area to provide this level of education training and the allied professions area, the paraprofessional category.

These 2-year institutions in most cases have already been established with the tax dollars and are existing and available. The Staten Island Community College of New York is having good experience in offering programs in hospitals ranging all the way from high school complex programs to staff and persons working in the VA hospitals as well as to patients within these installations. Our colleges very much want to undertake these programs but because of the high cost of paramedical programs are limited as to the number of students that can be served.

Senator CRANSTON. Why is the paramedical cost high?

Mr. LOWERY. Usually requires a smaller teacher/pupil ratio. For example, in taking students into the operating room the hospitals will not allow students in without an instructor with them. The ratio of students per teacher there is about 1 to 3. Usually the personnel problem is the basic one of the cost of these programs.

The community colleges are making an effort to establish counseling programs within the VA hospital to assist veterans who are nearing discharge so that they may in turn get into a relative program when they are discharged.

In closing, in my own particular institution we are making quite an effort through cooperation with OEO, the WIN program, Model Cities and other Federal agencies to get persons off the welfare roles and into self-supporting situations, and the opportunities in the allied health areas offer quite an opportunity for these types of persons because the training period is relatively short.

Thank you very much for listening. The community colleges stand ready to assist in this program.

Senator CRANSTON. Thank you very much, Mr. Lowery.

I am delighted with your testimony and want the record to show that I greatly appreciate the outstanding cooperation my subcommittee has received in this Congress and the last from the American Association of Junior Colleges and particularly from your veterans affairs director, Dr. John Mallan. I plan to continue to work closely with the American Association of Junior Colleges in the area of allied health training as well as the PREP program providing education for disadvantaged veterans. I plan to propose legislation to modify some of the PREP enabling provisions. I have recently had discussions with Secretary of Defense Laird about the need for a stronger, centralized Department of Defense position in support of that program and am hopeful some affirmative action will result from this conversation.

I am aware of the hospital visiting days in which you have participated and I strongly urge you to continue that.

Is your school associated with a VA hospital?

Mr. LOWERY. Yes, it is.

Senator CRANSTON. What has been your experience particularly? How many have been trained that could not have been trained otherwise?

Mr. LOWERY. Especially in the area of operating room technician training. There are not enough operating rooms except through VA in this particular instance.

Senator CRANSTON. Have you been successful in enrolling veterans in health-related programs?

Mr. LOWERY. Not as successful as we would like to be. The ones that we have seem to attract the females rather than the males.

Senator CRANSTON. Have any equivalency examinations been offered for these veterans who have had considerable health-related experience such as medics and corpsmen?

Mr. LOWERY. Yes, there have. Probably Dean Hartley might be able to answer this a little bit better than I would be able to, being a specialist in the health area.

Senator CRANSTON. Could you, please?

Dean HARTLEY. Yes. In the area of program plannings the students may take exemption examinations and fit right into existing 2-year programs and also may shorten the certificated courses in order to be able to work and go to school at the same time.

In supporting Senate bill 2219 I, too, of course, endorse the standard American Association of Junior Colleges. I wish to address myself to the impact of the legislation at the local and State level in which the improvement of patient care and education through a systematic health, manpower, education, and training program can develop through this bill. The State of Florida, of course, has had a great population increase and we do have to face the fact that we have many senior citizens over the age of 65 still with us and we have still our World War I, World War II, and now our Vietnam veterans coming back into our veterans hospitals in the State of Florida.

We have a system of junior colleges in Florida of 28 which cover the entire State so that there is a junior college available for all adults who wish to have education beyond the high school level and in the area of vocational technical education within the State of Florida.

Our university system has developed so that there is a university system and three medical schools in rather strategic places throughout the State and we have one allied health university program at the present time. These will give our junior colleges a system, our universities working with our junior colleges, and at the local level we will be able to bring continuing education to our allied health workers in our hospitals and nursing homes.

The five veterans hospitals are located in Miami, in Lake City, in Gainesville, and in Tampa where the new medical school will be and in Pinellas County Bay Pines Veterans Hospital. We have just received over a hundred Vietnam returnees at Bay Pines and it is a 660-bed hospital. We will have an expansion and there are still patients on waiting lists to come into this veterans hospital. I think it is very important that we realize a great deal of work has been done with the junior colleges and existing veterans hospitals.

The first nursing program in the State of Florida was started at our college at St. Petersburg Junior College. At that time there were 17 diploma schools supplying nurses in three university baccalaureate programs in the State. Today there are 17 junior college programs and only one diploma school left in the entire State so we are developing systems of education in order to bring this at the basic local level for people.

The use of the veterans hospitals is varied and I would like to have in the record some of the things that are going on with the junior colleges in the State. First of all, there was a shortage of psychiatric experiences for nursing students and we had to send students out of State for this educational experience. Where we have our veterans hospitals these are being utilized by all of your junior colleges for this kind of unique experience as well as medical/surgical and the medical/surgical specialty areas.

We have had the cost for the allied health programs coming to the junior college as has been explained by Dr. Lowery through the resource and competition with the general liberal arts education as well as the allied health. I would like to add one of the other facets on the expensive cost of the allied health in junior colleges is there is a shortage of faculty members prepared in these fields. There is also very expensive equipment and this equipment for colleges to buy is too expensive and therefore we do take our students where the equipment is located.

So when we have a veterans hospital we do have some unique equipment and this does increase the cost of the existing programs that don't have any facilities. Our dental hygiene program has been using the clinical facilities at Bay Pines, our dentists at Bay Pines Hospital come and lecture to our students in the college. They also come and have been put on television tape for us when they are not available and then these are used for upgrading and continuing education for the dental hygienists who are in the community and within about the radius of four counties that are included in dental hygiene programs.

In the adult education area, the Bay Pines Hospital over 10 years ago started some adult courses at our college in which we did some teaching in the field of gerontology for professionals and this was a multidisciplinary approach, which is most essential. We also had available through the VA hospital a Ph. D. in charge of the department of speech. This was not available locally and this particular person taught evening courses so that the professionals could upgrade themselves in dealing with the patients who have strokes as well, the veteran as well as our aged population in our hospitals and nursing homes.

Besides the adult education programs our particular college has just received some seed money to work with the Florida regional medical program to put on a model for the county for continuing education. Bay Pines Hospital's chief nurse and inservice director and their administrator have been on the planning committee for this for over 4 years so they are a model and they are part of the 17 hospitals that will cooperate within the county.

My stress is we must have lack of duplication, we must have coordination. We have limited manpower for teaching and we must do this. So this bill certainly feeds into this particular area.

Our junior colleges in many places around the country have spent much money and have had Federal help in doing programs in directed studies. We have been working with individual veterans and also patients at Bay Pines who come in and go into the directed studies program so that they may then fit into either the 2-year associate degree programs or the certificated programs. The Bay Pines Hospital has had nursing students using clinical facilities now. We had the first contract I believe over 14 years ago so it is not new education. We have been able to expand our program. Where we were putting out years ago approximately 23 graduates a year, we are now putting out 75 just from our own junior college in the community.

All of those students go through their experience at the veterans hospital as well as local. We also have been doing independent study models and these can be used for continuing education. If this model goes through as it should, the lack of duplication will be built into the system so that we will service through the junior college the entire 17 hospitals and their input into this with hardware and software and continuing education.

The use of corps courses and the use of, as you mentioned before, examinations for exemption have been utilized and are being utilized so that we can feed them into a lateral approach as well as they should be able to have mobility within a lattice work approach. We find an emergency medical technician program of one semester students coming out of the service particularly like this kind of program. They go into ambulance work and they go into emergency work.

On an individual counseling basis we have had students who were nurse attendants at the hospital who went to school at night for general education who had their hours arranged by the veterans hospital and worked at night, supported a family, and within a 3-year period received their registered nurse certificate. This particular illustration, this particular person is now a registered nurse in that veterans hospital. This is the point of coordinated planning that can be done and that your bill particularly emphasizes.

I would like to make one other plea and that is we need some source, some area by which the junior colleges may do innovative models where we may work at the community level so that the veterans hospital group and facilities would be available so that we can try the models out in the clinical setting of the VA before it gets into the system. We have too many splintered duplicated systems. I also would like to say that the system of education already existing within our State can handle the basic program and I am pleased to see that it would be in support of the educational system in which we may get our clinical support.

I would like to mention as well in high population areas the cost of land for building junior college facilities for these expensive multiple laboratory areas are going very high so that it would be of great benefit to the junior colleges if there was land and buildings that might be utilized for this expensive facet of the educational program.

There are many other areas I am sure in which by coordinating and cooperating we can come up with the support of an existing system. Within 2 years we are going to be in an even greater manpower crisis. We have the machinery that can fit right into this bill in the whole system of junior colleges developed throughout the country. I strongly endorse this and appreciate this opportunity to interpret at the local level and the area for the veteran and an improved patient service educational system for health manpower.

Senator CRANSTON. Thank you very much. That is most helpful to us.

You skipped over some material, I noticed. If you would submit that for the record, we would welcome it.

Dean HARTLEY. Thank you.

Senator CRANSTON. Thank you.

(The prepared statements of Paul J. Lowery and Nancy Hartley follow:)

STATEMENT OF PAUL J. LOWERY, SUPERINTENDENT, DES MOINES AREA COMMUNITY COLLEGE, DES MOINES, IOWA, ACCOMPANIED BY NANCY HARTLEY, DEAN OF INSTRUCTION, HEALTH RELATED PROGRAMS, ST. PETERSBURG JUNIOR COLLEGE, ST. PETERSBURG, FLORIDA

Mr. Chairman and Members of the Committee, I am Paul J. Lowery, Superintendent, Des Moines Area Community College, Des Moines, Iowa. I am here today on behalf of the American Association of Junior Colleges, to speak in favor of S. 2219.

I am accompanied by Dean Nancy Hartley, Dean of Instruction for Health Related Programs at St. Petersburg Junior College, St. Petersburg, Florida.

I will testify in favor of S. 2219 from the view point of a president and superintendent of a community college. Dean Hartley will give you her views from the viewpoint of a specialist-administrator in the field of health-related education.

S. 2219 is intended to help meet the nation's very urgent need for more trained health personnel at all levels—doctors, dentists, nurses, allied health specialists of all kinds. It is intended to expand and improve the Veterans Administration medical system, already the largest medical system in the United States, so that it can do a better job of serving returning veterans and the whole community. It is also intended to help create new institutions for health education and training and to expand existing institutions.

The American Association of Junior Colleges is in complete agreement with the purposes of this legislation. There are now approximately 1100 two-year community and junior colleges in the nation, enrolling about 2,500,000 students.

These junior colleges already offer health-related programs to many thousands of students. There are approximately 350 nursing programs at junior colleges, and in many states the hospital diploma schools are being phased out in favor of two-year nursing programs at junior colleges.

There are also an estimated 1,300 to 1,400 other allied health programs at junior colleges, leading to an Associate in Arts degree—programs in many fields of allied health. There are some 600 other programs less than two years in length, leading to certificates in various health fields. About 120 of these programs are community service programs, serving adults, many of whom are working in hospitals or elsewhere while completing their course work.

Most junior colleges are whole-heartedly in support of the "New Careers" or public services-human services education approach, which emphasizes programs in which the relatively unskilled can take courses part time to upgrade themselves economically and professionally. It is possible, for example, for a low-skill hospital employee who has not completed high school to take evening or part time courses to pass a high school equivalency examination, then take courses to become a nurse's aide or assistant, continue to work, and perhaps in time become a nurse.

Junior colleges therefore will become the opportunity to work cooperatively with the Veterans Administration, to help train and upgrade VA employees and at the same time to expand the college's capacity to provide health-related programs which will serve the whole community.

We are informed that at least 84 two-year colleges already cooperate with Veterans Administration Hospitals in providing clinical training for students enrolled in health-related fields. Some colleges have had a long and close relationship with VA hospitals. Many others would be most interested in developing such relationships.

The American Association of Junior Colleges has already testified on legislation similar in intent to S. 2219—the bill which has become H.J. Res. 748. Our organization testified on May 13 of this year in favor of the general approach of this bill, which was filed by Representative Olin E. Teague, Chairman of the House Committee on Veterans Affairs. We are pleased that the Chairman and Members of the Committee saw fit to amend the original bill and include support for allied health education programs, the position which we supported before the committee. This bill has passed the House, and is now before your committee along with S. 2219.

S. 2219, of course, is an especially good piece of legislation in terms of the nation's needs and the needs of veterans. It would provide $125 million a year for health education and training, and would make substantial sums available for the expansion of present health, nursing, and allied health education programs as well as for the establishment of some new schools.

We are also pleased that S. 2219 would give attention to such objectives as improving the methods of education and training now used in the health fields; helping to attract qualified veterans, including former medics, to these fields; developing cooperative relationships between the health and the allied health professions: developing new kinds of health-related fields: and recruiting individuals who are financially or educationally disadvantaged into the health fields. These are all high-priority goals of junior college health-related programs.

In closing, I would like to mention two or three areas which really interest junior colleges.

The *first* is the attracting of more returning veterans and servicemen into health-related fields, including medics but not limiting ourselves to medics. We believe that this has great possibilities, and that not enough is now being done by the federal government. During the past year, Dallas County Junior College in Texas has had a grant from the U.S. Public Health Service for a program to train returning medics in these fields. We hope that this program can serve as a model for similar efforts in other states, but we believe that the federal government will have to invest more funds and staff effort to make this work.

The *second* area which interests us is finding more ways to establish cooperative education and training programs for Veterans Administration staff at junior colleges. At present, Staten Island Community College in New York City, which has an outstanding program for veterans and servicemen, is working closely with the Bronx Veterans Administration Hospital to set up a pilot program which would apparently be the first of its kind in the United States.

Staten Island Community College is considering offering at least three different kinds of programs at the hospital:

High school completion programs leading to the equivalency examination, for the large number of staff as well as patients who do not have a diploma;

College preparatory or refresher courses, for both staff and patients needing refresher work before they undertake postsecondary education;

Allied health and paramedical programs, designed for staff who wish to upgrade themselves.

The AAJC has had letters and communications from colleges in all parts of the country indicating an interest in setting up educational and training programs at VA hospitals, for both patients and staff. It is our hope that the Bronx project will be a model for many others.

Our colleges want very much to undertake these programs. But because of the high cost of many paramedical programs, the funds which would be made available in S. 2219 are essential to our work.

The *third* AAJC goal, related to the second, is to establish educational and counselling programs for patients at both VA and military hospitals. The AAJC Program for Servicemen and Veterans has already established educational programs for disabled or wounded patients at Walter Reed Hospital in Washington, D.C., Valley Forge Hospital in Pennsylvania, Fitzsimmons Hospital in Denver, and Madigan Hospital in Tacoma, Washington. We hope to establish a much larger program at Walter Reed Hospital, and to work at other military hospitals as well.

Furthermore, we would like to see educational programs for patients at many of the VA hospitals across the United States. Some of our colleges have participated in "hospital visiting days" at VA and military hospitals, talking to servicemen about going back to college; we would like to see many more such projects, and would welcome the cooperation of the military and the Veterans Administration.

We believe that S. 2219 is an outstanding piece of legislation. We hope that Congress will pass it and fund it at the level of $125 million.

I will now ask Dean Nancy Hartley to talk about her experience with health-related programs and with the Veterans Administration.

STATEMENT OF NANCY HARTLEY, SPECIALIST, HEALTH RELATED PROGRAMS, ST. PETERSBURG JUNIOR COLLEGE, ST. PETERSBURG, FLA., ON BEHALF OF THE AMERICAN ASSOCIATION OF JUNIOR COLLEGES

Mr. Chairman and Members of the Committee:

I am Nancy Hartley, a Specialist for Health Related Programs, St. Petersburg Junior College, St. Petersburg, Florida.

I wish to address myself to the impact such legislation will have at the local and state level in improving patient care through improved, expanded and a *systematic* health manpower education and training program. I wish to endorse the stand of the American Association of Junior Colleges and Senate Bill 2219.

In order to illustrate *present* services rendered by the Veterans Administration hospitals and community college cooperation, I will use the State of Florida as an example.

There has been a great general population increase as well as increase in the numbers of people 65 years of age and older (both veterans and non-veterans). Florida has completed its long-range statewide plan for a system of community colleges within commuting distance of every adult in our State. The system is composed of 28 community colleges. The university system also has been set up on a statewide plan and developing so that there are regional areas composed of a major university with satellite campuses and community colleges within the specific regions.

The use of educational compacts or agreements has been in existence for some time. There are presently five Veterans Administration hospitals in the State, located in different educational regions. These are located at Gainesville, Lake City, Tampa, Miami, and Bay Pines (outside the city of St. Petersburg). All five hospitals have been servicing junior colleges in the realm of providing clinical learning experiences for students in nursing programs for at least seven years. Presently there are seventeen registered nurse associate degree programs and only one hospital diploma program in the State. The nursing programs at the baccalaureate and master's levels, as well as the associate degree programs, utilize the VA hospitals' clinical areas. A critical shortage of approved clinical learning laboratories in hospitals and other health agencies is beginning to occur, with medicine, dentistry, and allied health occupation workers being trained in university, junior college, and vocationally-oriented programs.

The cooperative educational relationship between a junior college and a VA hospital started in 1964 (seven years ago) when we at St. Petersburg Junior College needed experiences in the clinical specialty area of psychiatric nursing. Previously it was necessary for the College to send students out of the State for experiences in special areas at the expense of the taxpayers of Florida. The cost of health manpower education should be when the taxpayer is well and not from funds when he is hospitalized, causing the cost of hospital care to increase. The cost should also come from existing educational systems and not create splintered systems.

The associate degree nursing program in our community has expanded from annually graduating 23 nurses in a three-year program to graduating over 90 registered nurses yearly. This was done through the use of VA hospital clinical input as well as the use of other health agencies in the community.

Bay Pines VA Hospital has a bed capacity of 660 general medical-surgical and psychiatric, plus 400 domiciliary beds; there is now under construction a nursing home care facility for 120 patients. There have been approximately 945 nursing students in the basic registered nurse program who have had clinical laboratory experience at the VA Hospital. An average of 62 Dental Hygiene students go through the clinic yearly.

PRESENT BASIC ASSOCIATE DEGREE HEALTH OCCUPATIONS OFFERED AT ST. PETERSBURG JUNIOR COLLEGE

I. *Registered Nurse Program*—Takes in two classes a year and had to turn away qualified applicants this year. We have been averaging 140 entering freshman students annually, entering either fall or spring session.

II. *Dental Hygiene Program*—Uses Bay Pines VA Hospital for experience for students, and the VA dentists assist by teaching on a part-time basis in the Dental Hygiene Department.

III. *Physical Therapy Program*—This was the pilot program for the State and it is now in its third year. Two classes have been graduated from the College, and 25 students have just been accepted for this fall. There is a real shortage of qualified instructors in this health field, and baccalaureate and master's level programs also need clinical facilities in order to prepare instructors. There is also a need for space for specialized laboratories for expansion of basic programs and for continuing education.

IV. *Health Care Management Program*—This program was developed through a grant, and prepares personnel in hospitals as unit managers, and prepares at a basic level nursing home administrators.

V. *Mental Retardation Program*—The program is coordinated with the Florida Division of Mental Retardation. *Three new programs* are presently on the drawing board. Frequently they start through evening courses so that students can work and begin to reach their goal of the associate degree technical level worker.

Inhalation Therapy, Medical Laboratory, and *Occupational Therapy* associate degree programs are in the planning stage.

Recreational Therapy, Fire Administration, and Police Administration programs are all technical, basic, associate degree programs in the urban safety area.

St. Petersburg Junior College has outreach programs and tutoring to the community through grants, and a pilot program for the blind with special equipment and teaching aids.

There is at present the problem in the system of VA hospitals training workers, such as in the category of "corrective therapists," who are able to work only in VA hospitals and are not eligible to practice in any civilian setting. The professional Physical Therapy Association does not encourage utilization of clinical learning experiences in these settings for the students in the approved associate degree level physical therapy programs. These "corrective therapy" workers cannot have career mobility within the health manpower educational system, by the VA educating them in isolation from career patterns.

I use this as an illustration of the need for the system of education and VA training programs being involved in joint planning and execution of programs placed in the educational system.

CERTIFICATED COURSES

Refresher Courses for Registered Nurses. St. Petersburg Junior College has retrained 15 registered nurses every 12 weeks, and has put back into nursing homes and hospitals an average of 60 registered nurses annually for the past six years. This retreading for second careers for women realistically deals with the fact that many registered nurses leave the profession to raise families and respond to the "empty nest syndrome" by preparing themselves to re-enter the field.

Present Short Courses, Certificated

1. The *Emergency Medical Technician* course prepares ambulance drivers, firemen, and emergency room assistants. The Public Health Department asked us to set up this pilot program, and the students are certified by Public Health after completing the course. The course meets the requirements of the American College of Orthopedic Surgeons of the American Medical Association.
2. *Surgical Tech-Aides* are prepared in 16 weeks to work in operating rooms.
3. Other courses are set up as requested by the community.

EXISTING COORDINATING RELATIONSHIPS, OTHER THAN THE BASIC ASSOCIATE DEGREE HEALTH OCCUPATIONS PROGRAMS

St. Petersburg Junior College has been offering community adult educational services, handled through health occupations, for many years. These special courses (both credit and non-credit) have been specifically set up to meet the employment needs of personnel from Bay Pines VA Hospital and other health agencies in the community. Such courses include: team nursing, gerontology, rehabilitation concepts in patient care, a series of workshops in hospital unit management, coronary care, and others. Seminars for dentists at the state and local level have been conducted in our Dental Hygiene Department clinical laboratory through utilizing the College's closed-circuit television system.

Individual members of the Nursing Department faculty have been active in consultation work with the nursing staff of the Bay Pines VA Hospital.

The Chairman of the Advisory Committee for the Inhalation Therapy Program is a medical doctor at Bay Pines who is responsible for the Pulmonary Resuscitation Laboratory at the Hospital. This physician, and others on various College advisory committees not only give to the local community their clinical expertise, but they frequently assist the College in giving a broad perspective in their fields. They assist in mediating professional differences, as well as act in a neutral role in the occasional interinstitutional competition that may arise between local hospitals and professional groups, so that the health occupation programs can maintain some system approach with standardization and quality control. They help maintain the career-change, flexible attitude in relation to students.

St. Petersburg Junior College, like many community colleges, has outstanding programs in Directed Studies, and we are using the independent study approach to learning. We believe we must start where the student is, and inherent in our planning is a strong counseling philosophy. Some students will take longer to complete a prescribed program, and we believe programs should be geared to meet the needs of individual students.

There are presently challenging examinations available for returning veterans, licensed practical nurses, aides, etc., who have been medics, as we have a beginning health core course for the two-year health programs in our College.

Continuing education model

Continuing education for persons in health fields is now being considered as a part of maintaining licensure and will probably be written into State law requirements in the near future. This has great implications for future staffing of all health units.

St. Petersburg Junior College has just been granted seed money, through a grant with the Florida Regional Medical Program, for a county *model for continuing education* for health occupations workers in cooperation with our fifteen hospitals in Pinellas County. There has been coordinating work with directors of education and training, inservice educators, hospital and nursing home administrators, and directors of nursing. This program has the endorsement of the Florida Nurses Association, the Florida Hospital Association, and the Division of Vocational Education and the Division of Community Colleges of the Florida

Department of Education; also, specific voluntary groups, such as the Gulf Coast Tuberculosis and Respiratory Disease Association, and the Suncoast Heart Association.

The model starts with the fifteen hospitals and the three levels of nursing service workers the first year, then there will be added allied health groups and all nursing home personnel. We will attempt to define more clearly the role of the junior college in assisting the health agencies in their continuing inservice education, working through the individual inservice directors with junior college continuing education coordinators. The goal is to plug in individual program instructional packages which may be used in all hospitals in order to do quality programs while avoiding unnecessary duplication of scarce software and unplanned hardware utilization.

Coordination with existing plans for health education training is essential (as noted in comprehensive and regional medical planning). Present programs, already short of State funds for vocational-technical health education, have been subject to great cutbacks in areas of adult and continuing education, as well as the basic health education programs.

Health education training programs are more expensive for the colleges to implement and maintain because of:

1. Expensive technical equipment and college specialized laboratories which utilize scarce space, as well as the expense of maintaining the laboratories.
2. Shortage of specialized qualified instructors and the need to continually upgrade instructors because of new techniques, such as coronary care courses.
3. Instructors' travel to and from clinical agencies (time cost and transportation mileage).
4. Smaller classes are required with lower student-teacher ratio because of the use of clinical facilities in patient care areas and need for selection of patients with particular conditions for learning purposes. (Inhalation Therapy students need assignment for therapy to patients with respiratory difficulties, as manifested in diseased conditions such as emphysema.)
5. The administration unit requires contract agreements and obligations as well as specialized advisory committee work and maintaining liaison with multiple and unique health agency facilities and personnel.

Students in health fields need more financial help than many students in other fields or in the general liberal arts. They frequently come from lower economic strata of society. Paying for tuition and more expensive medically-oriented books is only part of the cost. These students frequently have families to support while keeping up in the more demanding health occupations.

An illustration of this point is as follows: Approximately seven years ago, a young man who worked as a nurse attendant at Bay Pines VA Hospital attended St. Petersburg Junior College at night, took the supportive education courses at night, then went full time in the day session with a lighter load. He received his associate degree in two academic years and two summers. The hospital kept him on night duty, the staff encouraged him, and when he finished he passed his State Board Examinations and remained at the Bay Pines VA Hospital in the new, more technical, registered nurse role. This was difficult, and the students with less funds and more family responsibility may become discouraged or through necessity drop out because of health or other reasons. The majority of students in health programs are usually highly motivated—this is noted by the teachers in the general college, patients, and the staff of the clinical agencies.

Consideration of specific areas for future cooperative expansion of health fields continuing education, and basic programs for meeting manpower needs at the local level

1. Continue to expand adult education credit and non-credit health fields courses with use of VA hospitals as satellites (or subsystems).
2. Have funds to tie in actual clinical learning situations with the radio-television department on the college campus, as well as with other hospitals in the county.

Educational research needed:

3. Curriculum implications a. care of the aged; b. core courses; c. rehabilitation; d. career ladder and lattice; e. more men in the health fields, not just predominantly male MD's and administrators; f. student-worker mobility, horizontally and laterally; g. innovative systems in continuing education; h. the open system for second and third career health workers; i. define explicitly the unique areas in health occupations programs.

4. An innovation center—experiment with above areas approaches; individual student educational diagnosing and prescribing, implementing and reevaluating, and recycling system to educate health fields workers.

5. Re-education in administration of medical and health services personnel, with various models being studied and piloted in various local and regional communities toward better utilization of the associate degree registered nurse and allied health workers, to give direct patient care in VA hospitals. Re-education of hospital administrative and medical administrative groups in VA hospitals in *more* than the medical model approach.

There is a great need for the VA hospitals to be prime movers in coordination with the local, state, and regional plans for a health training system approach to meet health manpower needs.

This Bill can be the basis for the upgrading of health workers through the ladder concept by certificated, associate degree, baccalaureate degree, and upward mobility for the health fields workers. *We must avoid setting up splintered patterns and expensive duplication of programs.*

Planning must help alleviate the needless duplication and competition that now exists, and must feed into the educational system and have input and feedback through both educational and health care delivery systems.

The colleges, through such a Bill, could: 1) expand existing programs and put out larger numbers of workers more rapidly; 2) provide multidiscipline laboratories that would keep down costs of duplication of expensive equipment; 3) assist with better utilization of scarce, highly-specialized instructors in health occupations; 4) have more clinical facilities of a variety of experiences available for teaching health workers; 5) establish a career ladder approach through a system of moving in and out of work and learning programs at the community level; 6) work through the educational system evaluation methods of programs; 7) do individual student teaching programs for returning veterans and the new careers persons.

There is a great need for health occupations educational innovative centers in the states. This Bill could assist in allowing the development of research of new programs (which is almost financially prohibitive by each individual public college). Their acceptance into the revision of the systems of health care that is practically upon us cannot be borne by college financing alone. When a form of true universal health care meets us in one or two years, there will be an increasing crisis in health manpower training sources. This Bill could be a vehicle through which programs can be studied in light of a coordinated system with the colleges conducting the ongoing programs. We must be vigilant that we do not have two distinct medical care systems develop in the United States.

The increase of cost of land and buildings for public community colleges is becoming critical. Existing land and buildings for the more expensive health programs could help keep the operating costs down for the taxpayers. The mobility of health workers throughout the country speaks for the need of more Federal support for their educational programs, rather than the states paying unevenly for expensive programs and the new graduates from health occupations moving freely throughout the country.

Locally, statewide, and nationally, the community colleges already have proven they can give the taxpayer (to quote a common expression) more "bang for the buck" with accountability through community involvement and feedback in educational programs.

They can, with the cooperation of the system of VA hospitals as defined in this Bill, be a part of a flexible, coordinated, educational system to prepare health occupations manpower for the future coordinated system of health care delivery for the people of this country. Perhaps the great thrust made through the VA hospital programs in the field of rehabilitation in patient care after World War II can be geared up to be as strong a thrust which is presently needed in the field of preventive medicine and patient education after the Viet Nam conflict. The Bill S. 2219 has the potential to bring about the above-stated system of education for health occupations manpower and therefore assist in the public's mandate that health care must be available to all citizens of the United States.

Senator CRANSTON. Because of lack of time, and in addition there is now a rollcall going on, I would like to ask you to submit for the record a bit of detail about the Dallas County Junior College program for training returning medics in health fields and specifically how much additional training was required. Were they given credit for training received in the armed services? Have the graduates a good potential for finding jobs in the future? I would like to have anything else you feel would be relevant and helpful.

The program you describe at Staten Island Community College and Bronx Veterans' Administration Hospital holds great promise, not only in educational programs in the health fields but in general educational programs for both patients and staffs needing to complete high school programs or needing college preparatory or refresher courses. I should think the program having particular pertinence to the bills we are discussing today is that of training programs in allied health and paramedical programs designed for staff wishing to upgrade the skills they possess.

Do you have information on the numbers of students who will be enrolled in these programs, or on the professional fields in which they will be trained?

If you don't, you can submit that for the record.

Mr. LOWERY. I have State figures.

Dean HARTLEY. I have State and local figures.

Senator CRANSTON. If you could pull them together and give us those, we would appreciate it.

(The material subsequently supplied follows:)

EL CENTRO COLLEGE—CIVILIAN RN TO ARMY MEDIC, NAVY CORPSMAN, AND AIR FORCE TECHNICIAN

MED-VET PROJECT ASSOCIATE DEGREE NURSING

Need

The demand for registered nurses is greater today than ever before in the history of our country as the demands for health care increase. Those who choose nursing as a career may expect many professional opportunities.

Program

El Centro College, through a U.S.P.H.S. grant has developed a program of Associate Degree Nursing leading to licensure. The project will grant college credit to military personnel who are prepared in bedside care of the ill. Through placement examination results, the individual program of study will be constructed to fit the needs of each student and allow him to master the mental and physical skills necessary to become a registered bedside nurse technician.

The program of study, open to men and women, provides a balance of science and general education courses in preparation for nursing. The student receives clinical laboratory experience in several Dallas area hospital and classroom work on the El Centro campus. At the completion of study, he is then awarded an Associate Degree of Applied Science and is entitled to write the National Test Pool Examination to qualify as a Registered Nurse (R.N.)

SUGGESTED PLAN OF STUDY FIRST YEAR

Fall Semester:	*Credit hours*
Nur. 132, fundamentals	[1] 6
Nur. 231, psychiatric (8 weeks)	5
Nur. 232, med. surg. (8 weeks)	5
Bio. 120, Anat. and Phy	4
Psy. 105 Introduction	3
Total	23

Spring Semester:	
Nur. 233 med surg	9
Bio. 121 Anat. and Phy	4
Eng. 101 Comp	3
Soc. 101 Introduction	3
or	
Psy. 201 Gro and Devel	3
Total	19
Summer Semester:	
Nur. 234 med surg	5
Elective	3
Total	8
Fall Semester:	
Nur. 133 Mat Ch Nur	8
Bio. 216 Micro	4
Eng. 102 Comp and Lit	3
Soc. 101 Introduction	3
or	
Psy. 201 Gro and Devel	3
Total	18

[1] Weekly seminar—no lab exper.

Admission requirements

1. Completion of military corpsman school
2. Graduation from an accredited high school or GED certificate
3. Medical examination (discharge physical accepted if within last twelve months)
4. Application and acceptance to the project
5. Interview (person, mail, or phone) with liaison counselor to the project
6. Admission to college for full time academic study
7. Transcripts of high school, military service school (DD214 form), and any other course work

Variation of the program

1. Students who find it necessary because of the intensity of the program, to spread the requirements over a longer period are encouraged to discuss degree plans with a member of the Associate Degree Nursing faculty early in their college career
2. Students with prior college work will be evaluated on an individual basis
3. Note: Students must attain a grade of "C" or better in every nursing course in order to continue in the program.

For further information and application materials please write or call: Med-Vet Project, El Centro College, Main and Lamar Streets, Dallas, Texas.

Tuition and fees

Students enrolled in nursing will be subject to the same tuition and student activity fees as all registered full-time students.

Tuition: Full-time Student:

Per Semester:	
Residents of Dallas County	$60
Residents of other Texas Counties	200
Non-Texas Residents	300
Student Activity Fee	7
Laboratory Fee and lab Course	2–8

Estimated Program Expenses:

Approximate total cost of the Associate Degree Nursing program, if completed in two years, includes:

Tuition and fees	$380
Books and school needs	585
Uniforms (includes caps and shoes)	70
Total	1, 035

These expenses do not include room, board, transportation or clothing costs.

Students should plan to have $200 available for initial expenses at the time of enrollment. Books and uniforms may be purchased through the campus bookstore.

Students in nursing are eligible for regular college scholarships and loans.

Med-Vet Project, El Centro College, Dallas, Texas

SUMMARY OF PROJECT

Purpose: The purpose of this study is to initiate, develop, implement and evaluate a curriculum within an Associate Degree Nursing program for veterans with past Medical Corpsman School training.

Objectives: (1) Encourage veterans with Medical Corpsman training and experience to enter the field of civilian nursing through the minimal R. N. preparation within the Associate Degree Nursing program: (2) Demonstrate that the existing skills, both mental and physical, can be utilized to reduce repetitive exercises that tend to decrease the motivation of student learning: (3) Adapt a curriculum of an Associate Degree Nursing program to enable the student to utilize the existing skills and to expand these to the level expected of the beginning technical nurse.

Phase I: This project, directed toward the veteran with Medical Corpsman School experience, will identify the commonalities in the terminal objectives for these graduates and the Associate Degree Nursing graduates.

Phase II: Data will be used to construct tests to identify the individual's levels of understanding and skills.

Phase III: Selection and admission of medical corpsmen to an Associate Degree Nursing Program will be followed by testing and individualized program scheduling based on test results. Identifying strengths and weaknesses of the individual will continue throughout the program for each student.

Phase IV: Follow-up studies will be carried out on all graduates. National Test Pool results for the students of this project and those in the regular program of Associate Degree Nursing will be compared.

Some of the anticipated outcomes of this proposal are: the identification of terminal objectives of the Army, Navy and Air Force Corpsman Schools; the identification of terminal objectives of an Associate Degree Nursing program; the development of objective tests for measuring terminal objectives; the utilization of appropriate learning strategies for terminal objective learning situations; an economy of time involvement for both the student and the community by utilization of past learning; stabilization of annual 40% R. N. turnover by encouraging males to remain in the health care field by completion of an Associate Degree Nursing program. There are probably many other outcomes that will exhibit themselves during the course of this investigation.

Senator Cranston. How many junior colleges are interested in developing this sort of program?

Dean Hartley. Developing the health programs with the veterans as such?

Senator Cranston. Yes.

Dean Hartley. I cannot speak for the rest of the country, I just know the five veterans hospitals within the State of Florida all have programs with the junior colleges in the allied health and nursing fields.

Mr. Lowery. I believe we could say all within reasonable physical distance would be interested.

Dean Hartley. May I also put in concerning one of the questions that you had that there was a tremendous shortage of clinical experience for teaching allied health and nursing people throughout the country. We are getting into this problem and this certainly would be of great benefit to be able to have the different levels of students of more experience in veterans hospitals.

Senator Cranston. I thank you very much. I apologize for the bit of a rush that I find myself in.

Now I have to recess just briefly to go over and vote, and I will be back shortly. We have two more witnesses.

Thank you.

Mr. LOWERY. Thank you.

Dean HARTLEY. Thank you.

(Whereupon, a short recess was taken.)

Senator CRANSTON. The hearing will reconvene.

The next witness is Mr. Patrick E. Zembower, Associate Director in Charge of Federal Representation, Economic and General Welfare Department, American Nurses Association.

I am glad to see you are accompanied by two young ladies. Would you please introduce them?

STATEMENT OF PATRICK E. ZEMBOWER, ASSOCIATE DIRECTOR IN CHARGE OF FEDERAL REPRESENTATION, ECONOMIC AND GENERAL WELFARE DEPARTMENT, AMERICAN NURSES ASSOCIATION, ACCOMPANIED BY BETTY COLEMAN AND RA SEDGWICK, REGISTERED NURSES

Mr. ZEMBOWER. Good afternoon, Senator.

I have with me this afternoon two registered nurses. I don't like to come before the Senate without having some expertise with me. I have on my left Miss Betty Coleman who has been a rather good student on this question of the physician assistant. I have with me also Miss Ra Sedgwick.

Senator CRANSTON. We welcome you. I ask again that you summarize briefly because of the time element.

Mr. ZEMBOWER. Yes, sir.

I have a statement which I submitted to the committee for the record and I would like to just comment briefly on some of the highlights of this statement.

First of all, sir, I want to commend the Senate for establishing a full Committee on Veterans' Affairs. I am sure that your interest in the medical care of veterans and your influence in the Democratic Party played a great factor in getting this full committee.

I also want to publicly thank Senator Moss for supporting legislation that would improve the personnel policies of the Department of Medicine and Surgery.

There is one correction I would like to make. On page 2 of my statement it seems like we left the most important thing out. At the bottom of the page we say that one of the problems was the patient load that frustrates the nurse in giving professional nursing care. I would like to add that to. The VA nurses in general only give priority nursing care because of so many crisis situations.

We would like to emphasize the need for shift differential because of the difficulty that recruiters are having in recruiting nurses for the VA system. I mention on page 4 that they are being hindered by a better fringe benefit in the salary package in the non-Federal hospitals and some parts of this benefit package deal with the fact of shift differential of nurses in non-Federal hospitals. Non-VA hospitals do not have to work as many tours of duty in 1 week. In those private hospitals they are beginning at higher steps in the salary scale. They are getting educational increments and they are also getting a choice of educational leave to complete their education.

Miss Sedgwick here with me today is completing her doctorate.

I have prepared some charts which I call to your attention in the latter part of the statement and I would like to mention our reservations about the proposed salary schedule you have made for the allied professionals which would include the physician's assistant. We as representatives of the nursing profession have some reservations about the introduction of the new health worker. However, we do not see how that move can be in any way hampered because it looks like it is a sure thing, it is a coming thing.

I would also like to call attention to your opening statement where you mention a new health worker as a nurse practitioner. I don't think you meant to say that but on the question of the allied professionals, including the physician's assistant, we are asking for the same kind of treatment for the registered nurse because the scale that you propose for an allied professional to begin at the second step of the AP-2 grade is the same salary that is earned by the full grade nurse who has completed, in addition to a successful preparation, 6 years of nursing experience.

Now I have given to you for your study a chart which shows the qualification requirements for a GS-9 physician's assistant which seems to be the level that physicians' assistants are being hired in the VA as civil service employees. This requires 3 years of experience. Now this is what is required in the VA of an associate grade nurse, 3 years of successful experience. An associate degree nurse we are proposing in our statement would start at $10,700 which is about comparable to the proposed starting salary for a physician's assistant.

On the question of shift differential the civil service employee now gets a 10 percent night shift differential. We think that the 10 percent is not enough in the VA because while 10 percent may be enough to compensate somebody for taking an undesirable shift, in the VA medical system these are really the tours of duty that require more work and attention of the practitioner. Even the nursing assistants are involved because so many of the services are either shutdown or curtailed a great extent, especially the laboratory, the pharmacy and other services.

I would like to ask the committee's special consideration for the proposal we have that is in Senator Moss' bill for on-call pay. This is one area, sir, that is different from S. 2354. Let me just briefly cite a typical example. My contact in the field is mainly with operating room nurses who have this problem and typically there are four OR nurses and they divide up taking call every other week or every other weekend so that there are two OR nurses on call at all times and they do not get any compensation for this. They have to remain close to their residence, close enough so that they could be at the hospital within 30 minutes' time. So we are especially emphasizing the need for this on-call pay at 25 percent differential for taking call.

In the Administration bill S. 1924 it is proposed only to compensate a nurse if she is called back and to guarantee them 2 hours pay. That is the only compensation proposed in the Administration bill.

That completes my statement, sir.

(The prepared statement of Mr. Zembower follows:)

STATEMENT OF PATRICK E. ZEMBOWER, FEDERAL REPRESENTATIVE, AMERICAN NURSES' ASSOCIATION

I am Patrick E. Zembower, Associate Director in charge of Federal Representation Economic and General Welfare Department, American Nurses' Association, the national professional association of registered nurses. The Association is concerned with the education, practice, and welfare of nurses, with the aim of better nursing care for all.

There are in excess of 25,000 civilian registered nurses in various Federal agencies. The largest group, totaling about 16,000, is employed by the Veterans Administration. Of these, 15,000 are full-time, the rest are regularly scheduled part-time nurses and intermittent hires.

Nurses, constituting the largest single body of health professionals in the country, bear a heavy collective responsibility for furthering the nation's health goals. The ANA recognizes that the quality and quantity of nursing care are indisputably related to the education and welfare of nurse practitioners and that effective nursing service requires full participation by nurses in shaping the decisions that effect the conditions under which they practice.

We are grateful for the opportunity to participate in the work of this Committee in your quest to identify legislative needs to enhance and improve the quality of health care we as citizens want for our veterans who have given so much of themselves in protecting the freedoms we enjoy as their fellow countrymen.

This is the first time I have had to testify before this committee. I want to commend the Senate for establishing a full Committee on Veterans Affairs. I want to congratulate this Committee for its diligence in sifting through the many complex problems presented to you and coming up with some meaningful proposals.

I, also, want to thank you, Mr. Chairman, and Senator Moss for your demonstrated interest in improving the personnel policies of the Department of Medicine and Surgery.

Last year I presented a bill of complaint to the other body. I do not want to repeat that presentment but I would like to summarize the problems that were identified by a survey of VA nurses in early 1970.

1. Staffing shortage of health professionals.
2. Underutilization of nursing skills.
3. Personnel policies of the Administrator under paragraph 4108 of Title 38.
4. Noncompetitive monetary benefits in the areas of shift differential, overtime pay, and pay for holidays, weekends and stand-by or on-call pay, with those in non-Federal hospitals.
5. Lack of effective grievance and appeal procedures.
6. Patient-load that frustrates the nurse in giving professional care.
7. Lack of supplies and equipment and/or trained personnel to operate sophisticated equipment.
8. Other essential departments, such as x-ray pharmacy and laboratory not covered around the clock.
9. Low morale of nursing personnel.
10. Reputation of VA's working environment hampering recruitment.

I believe that Congress was listening and made a sincere effort to change things. We have seen the evidence in an increased budget and the legislative proposals we are considering today. It is too early to see the improvement anticipated by an increased budget, but I have been receiving encouraging reports that recruitment drives have been intensified. The decline that set in with the implementation of the Revenue and Expenditures Control Act of 1968 is being reversed.

The recruiters are being hindered with a more competitive salary and fringe benefits package being offered in the non-Federal hospital sector.

Paragraph 4108 of Chapter 73, 38 USC, gives the Administrator of Veterans Affairs the right to prescribe the hours and conditions of employment and leaves of absence of physicians, dentists and nurses appointed to the Department of Medicine and Surgery. It has been prescribed that Title 38 professionals shall be available for duty 24 hours a day, 7 days a week, that a nurse shall begin duty when she reports for work and continue until excused by proper authority, that she shall have non-duty days each week known as "administrative non-duty days," that when non-duty days fall wholly within a period of approved leave all days shall be charged to leave, that annual leave shall be accrued and used at a minimum of one day or multiples thereof, that employees shall earn annual leave at the rate of 30 days per year and sick leave at the rate of 15 days, and the maximum annual leave accrual shall be 120 days. Class Act employees earn annual leave after 15 years of service at the rate of one hour for each pay period and accrued to 240 hours. When used it is charged at a minimum of one hour or multiples thereof.

When nurses complain to me about the Title 38 leave policy, I remind them that VA nurses earn 30 days leave the first year, while Class Act employees have to wait until the 15th year to earn their full leave benefits. But, the nurse quickly knocks the argument down when she shows that Class Act employees do not lose their days off when 7 days annual leave is taken. She shows that even though the nurse may get 30 days annual leave when you divide 30 by 7 calendar days it leaves 4 weeks, plus two days. While the Class Act nursing assistant earning 26 days leave per year divides 26 by 5 days to provide 5 weeks, plus one day for leave purposes.

Recently I received a call from a nurse, who is presently practicing at the U.S. Soldiers Home, to inquire about the working conditions in the Washington VA Center. She was considering transferring to the VA. She has served the Home for seven years as a night nurse. My first response was to say that the VA has a special entrance salary in the Washington area. When I repeated the special beginning salary for a full grade nurse, she said that it was $3 less than her current salary. I was surprised. I have believed that VA salaries are a notch above other Federal hospitals to compensate for the employment condition requiring VA nurses to be available for duty 24 hours a day, seven days a week, without overtime pay and shift differential.

I have heard this claim so long that I was beginning to believe it. The claim is made by the VA, by the Civil Service Commission and others. To put it as mildly as I can, I think now—that the claim that VA nurses receive a higher salary to compensate them for the things she lacks that other employer's pay is pure balderdash.

I believe the higher salary was intended to attract and retain the best qualified practitioner. What was an advantage a few years ago has been lost to the rapidly changing economic scene. Nurses in Baltimore City received a 10% salary increase last year while other city employees settled for less. Last year the CSC had to make two special upward adjustments for nurses employed in the Federal hospitals in the Baltimore area, because of the private and public sector competition. In New York City, the starting salary for nurses in non-Federal hospitals is higher than the top step in the Junior Grade.

Nurses in San Francisco are starting at $9828. An OR nurse is starting at $1200 more. We believe that members of this Committee are sincerely interested in upgrading nurse salaries. One way to begin is with the level that professional nurses enter Federal service to give parity with other professionals.

A study was made in Buffalo. A nurse was compared to an accountant, chemist, and engineer employed by the VA. The comparison showed that the nurse had to stay in the Associate grade three years before reaching Full grade while the other professions could reach the equivalent of GS–9, step 1 in one year.

To further compound this obvious pay discrimination is the introduction of the employment of physicians assistants into the VA system. S. 2354 proposes a new salary schedule for Allied Professionals. Among the allied professionals is the physician's assistant. It is proposed that a PA start at a grade level not less than AP–2 at $10,470 per annum. This is the same salary for a full grade nurse who has had six years of nursing experience after completion of her nursing preparation. We do not oppose the recommended salary for PAs, but why not the same consideration for RNs? I have developed Table 4 to show the pay linkage of the proposed pay schedules. ANA also proposes a new salary schedule for professional nurses.

RECOMMEND AMENDMENT TO 4103 AND 4107 OF TITLE 38

ANA proposes a new nurse salary schedule to regain the earnings advantage that was originally envisioned in Public Law 79–293 and to upgrade salaries to compensate nursing for increased duties and responsibilities in the rapidly expanding role of the nurse practicing in the contemporary medical and nursing technology. This proposed schedule also endorses the new grade level for the Director of Nursing Service as proposed in S. 1924 and S. 2354. The proposed schedule is:

ANA PROPOSED NURSE SALARY SCHEDULE

	Minimum	Maximum
Director of nursing service	$32,546	$42,308
Director grade (new)	28,129	35,633
Assistant director grade	24,251	31,523
Chief grade	20,815	27,061
Senior grade	17,761	23,089
Intermediate grade	15,040	19,549
Full grade	12,615	16,404
Associate grade	10,757	13,917
Junior grade	8,582	11,156

So you may have a better understanding of the education and experience required for these different levels, I have summarized the VA qualification standards in Table 1. A comparison of the current salary schedule with the various proposals are shown in Table 2. A comparison of the education and experience requirements for a full grade nurse and a GS-9 physician's assistant appear in Table 5.

SHIFT DIFFERENTIAL

ANA favors the 15% differential for the evening and night tours of duty, as such. S. 1924 proposes a 10% differential to compare to the differential paid Class Act employees. 10% is not "enough" RNs deserve more for their professional services because of the lower ratio of employee to patient on the odd-hour shifts when many of the supporting services are either closed or greatly reduced. It is on the evening and night tours that the nurse on duty frequently has to assume the responsibility for patients in two or three wards.

PREMIUM PAY FOR WEEKENDS AND HOLIDAYS

ANA supports the overtime and premium pay provisions of the Moss Bill and urges this Committee to favorably report out S. 1635. The amendments contained in Sec. 202 (h) (1) through (12) of S. 2354 are similar in content to those contained in S. 1635 with two major differences. S. 2354 provides for compensatory time for the 15% shift differential which I believe is not administratively possible. And S. 2354 does not contain standby or on-call pay which is badly needed to fairly compensate RNs who are frequently required to take call, especially the nurse assigned to operating rooms and intensive care units. See Table 3 for a comparison of legislative proposals on premium pay.

AUTHORITY TO ESTABLISH HIGHER MAXIMUM RATES

We want Congress to give the Administrator authority to establish higher maximum rates of pay on a nationwide basis so as to provide basic compensation commensurate with competitive pay practices. When the Administrator establishes special entrance salaries to recruit and retain health professionals the top of the grade is unchanged and the rates are thereby compressed destroying the reward for longevity. H.R. 37 contains this desirable provision.

CONTINUING EDUCATION

Dr. Hildegard Peplau, president of ANA, describes today's nurse role model in her cross-country talks to nurses.

"The basic roles in nursing were mostly comfort inducing: Bathing, feeding, toileting, and medicating. These activities are known as bedside nursing.

"Nurses are also concerning themselves with the interaction phenomena—between patients, within families and communities—as these impinge upon health. Nurses are extending their concern about the environment within which a person becomes ill, or gets well, or stays healthy."

"In their extended roles nurses are concerning themselves with the reactions of the patients to their predicaments—to the disease, trauma, transplant, amputation, or whatever has been experienced."

Because of these changes in nursing—partly a result of fewer patients being bedfast and partly due to more complex practices and a new preventative focus—Dr. Peplau urges further education for nurses, to keep pace with a rapidly changing, advancing profession.

The ANA supports the ideas of continuing education for nurses, and other health professionals. There is however the problem of making the nurse profession more attractive to young people to get them interested in selecting it as their life's work. The proposals we have made to provide shift differentials, premium pay, overtime and on-call pay for VA nurses have been characterized as demands that would be made by a labor union. Something out of the greed of the market place. We have not been motivated by such thoughts. Our motivation stems from one objective:

> To ensure for the future an adequate supply of a key health worker-professional nurses to supervise the delivery of nursing care to our veterans.

Thank you, Mr. Chairman.

TABLE 1

Basic requirements for appointment and promotion to nurse positions [1]

Junior grade—Graduation from a school of professional nursing.

Associate—Bachelors degree with major in nursing *or* two years of successful practice.

Full—Six years of practice *or* 15 courses toward degree in nursing and five years of practice *or* Bachelors degree and three years of practice *or* Masters degree and one year of practice.

Intermediate—Bachelors degree and six years of practice *or* Masters degree and four years of practice.

Senior—Bachelors degree and nine years of practice *or* Masters degree plus accomplishments in administration of a Nursing Service or nursing education program.

Chief—Bachelors degree and 12 years of practice *or* Masters degree and 10 years of practice, plus accomplishments in administering a large and complex Nursing Service. Experience must have been in several hospitals or health facilities.

Assistant director—Bachelors degree and 15 years of practice *or* Masters degree and 13 years of practice, plus accomplishments in administering a Nursing Service in a variety of complex situations.

Director (proposed)—Joint study by the VA and the CSC revealed that certain positions new at the Assistant Director grade level which equates in pay to GS–14 under the General Schedule were superior to that grade relationship.[2]

Director of nursing service—Occupies that position in Central Office.

TABLE 2.—A COMPARISON OF THE PROPOSED NURSE SCHEDULES

	Current	S. 1924	ANA
Director of nursing service:			
Minimum	$24,251	$32,546	$32,546
Maximum	31,523	36,886	36,886
Director grade:			
Minimum	None	24,251	28,129
Maximum		31,523	35,633
Assistant director grade:			
Minimum	20,815	20,815	24,251
Maximum	27,061	27,061	31,523
Chief grade:			
Minimum	17,761	17,761	20,815
Maximum	23,089	23,089	27,061
Senior grade:			
Minimum	15,040	15,040	17,761
Maximum	19,549	19,549	23,089
Intermediate grade:			
Minimum	12,515	12,515	15,040
Maximum	16,404	16,404	19,549
Full grade:			
Minimum	10,470	10,470	12,615
Maximum	13,611	13,611	16,404
Associate grade:			
Minimum	9,026	9,026	10,757
Maximum	11,735	11,735	13,611
Junior grade:			
Minimum	7,727	7,727	8,582
Maximum	10,049	10,049	11,156

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[1] VA Manual MP–5, part II, Chapter 2, App. 2E.

[2] "The Federal Salary Comparability Process," Office of Management and Budget. Civil Service Commission. *January, 1971.*

TABLE 3.—COMPARISON OF PREMIUM PAY BENEFITS

S. 1635	S. 2354	S. 1924
Shift differential 15 percent for evening and night tours of duty	Same	10 percent for each hour worked up to 8, between 6 p.m. and 6 a.m.
Saturday 20-percent differential for period of such duty	do	
Sunday 30-percent differential for period of such duty	do	25 percent.
Holidays 100 percent for regular shift and 200 percent for overtime	100 percent	100 percent for regular 8 hour schedule.
Overtime 150 percent for hours worked in excess of 8 per day	Same	Same. Overtime must be 15 minutes or more to be creditable.
6th consecutive day of work in a workweek 150 percent	do	
7th consecutive day of work 200 percent	150 percent	
Compensatory time in lieu of pay	Same	
Standby or on-call pay at rate of 25 percent		

TABLE 4.—LINKAGE—PROPOSED PAY SCHEDULES IN S. 2354

Grade	Physician and dentist	Nurse	Allied professional	Health technician	Minimum	Maximum
GS-3				HT 1	5,524	7,180
GS-4				HT 2	6,202	8,065
GS-5				HT 3	6-938	9,017
GS-6		Junior		HT 4	7,727	10,049
GS-7			AP 1	HT 5	8,582	11,156
		Associate			9,026	11,735
GS-8				HT 6	9,493	12,337
GS-9		Full	AP 2	HT 7	10,470	13,611
GS-11	Associate	Intermediate	AP 3	HT 8	12,615	16,404
GS-12	Full	Senior	AP 4	HT 9	15,040	19,549
GS-13	Intermediate	Chief	AP 5		17,761	23,089
GS-14	Senior	Assistant director	AP 6		20,815	27,061
GS-15	Chief	Director	AP 7		24,251	31,523
	Executive				26,143	33,982
GS-16	Directors		AP 8		28,129	35,633
GS-17	Medical director	Director of nursing services.			32,546	36,886
	Assistant chief medical director.				37,624	
GS-18	Associate deputy chief medical director.				36,000	

TABLE 5

Veterans' Administration requirements for appointment to full grade

Graduate from School of Nursing.

Licensed to practice in any State.

Six years of successful nursing practice or 15 courses toward a degree in nursing and 5 years of practice or BS degree and 3 years of practice or MS degree and 1 year of practice.

And, the candidate, in nursing practice must have demonstrated accomplishments in:

(*a*) Identifying and assessing patients' nursing needs and planning and evaluating nursing activities which have produced identifiable improvement in services to patients.

(*b*) Stimulating constructive action in developing and carrying out individual nursing care plans or training programs for Nursing Service personnel.

(*c*) Recognizing the need for and initiating action in individual and/or group projects.

(*d*) Giving direction to others and maintaining self-direction within limits of professional expectations.

Civil service qualification standards for GS-7 and GS-9 physicians' assistants

For GS-7

For the entrance level of GS-7 you must meet both requirements (1) and (2) below:

(1) You must have a broad background of knowledge of the medical environment and medical practices and procedures such as would be acquired by a

bachelor's degree in a health care occupation such as nursing, medical technology or physical therapy or by 3 years of responsible and progressive health care experience such as medical corpsman, nursing assistant, or medical technician, and—

(2) You must have successfully completed an appropriate course of study of at least 12 months, including clinical training or preceptorship, specifically designed for professional-caliber physician's assistants in that it provided the knowledge and ability to take a detailed medical history, to conduct a physical examination, to follow observation procedures, to order and perform diagnostic and therapeutic tasks, and to exercise a degree of judgment in integrating and interpreting findings on the basis of general medical knowledge; or equivalent education and training.

For GS–9

You qualify for GS–9 if you meet the requirements for GS–7 and have 1 year of pertinent professional-caliber experience comparable to the work of a physician's assistant, or—

If you have completed 3 full years of a curriculum in an accredited medical school leading to the doctor of medicine or doctor of osteopathy degree.

Mr. ZEMBOWER. I would like to ask Miss Coleman to comment on the information that she has concerning the qualifications of the physicians' assistant for your information.

Senator CRANSTON. Fine.

Miss COLEMAN. Senator Cranston, thank you for the opportunity to present some information to you just extemporaneously.

Senator CRANSTON. Delighted to have you do so.

Miss COLEMAN. I was not here for your opening statement but I am interested in your feeling that this new health worker, seeing this person as a nurse practitioner, because I as an individual nurse agree that this person is indeed within nursing personnel ranks—at what level I think that both the medical societies and the American Nurses Association and their subsidiaries should determine.

I feel quite concerned that nursing has not been involved in the preparation and training and decisions regarding the profession, that we should demand to be rather than made to be. On the qualifications I think that frankly my own reason is that they are discriminatory in that the nurse is so limited and I think again it is because of the female occupation and that physician's assistants mostly are men, and we certainly need more health workers.

With this experience in nursing it would be the appropriate people to employ this way and to train this way. For example, just this morning I called Walter Reed Hospital to find out what the line of authority, if you want to call it that, in medical corpsmen are presently in hospitals in the military, and it is my understanding from them that medical corpsmen and nurses are included under the series called 91–Cs and these people are responsible to a ward-master who in turn is responsible to the head nurse and she in turn with medical questions would approach the medical officer. Now I think this substantiates the nursing position that the experience with which the medical corpsmen are getting and which they are having an opportunity to go forward into these programs are indeed nursing situations.

I think in terms of some of the things that Mr. Zembower has said my own feeling sometimes has been that the whole hospital structure has to be changed and I feel that the Veterans' Administration might be a good place to start it. For example, instead of at times more money, perhaps fewer hours—instead of 8-hour shifts, perhaps 6-hour shifts with duties divided differently, and this might retain more nurses in employment in a 30-hour week.

I think that a 30-hour week in nursing service would be fair while others might work a 40-hour week for the reason that other occupations do not have to work weekend shifts and holidays. I think that this might be the better remuneration, fewer hours work, and retain more women in jobs. As you know, most nurses are women and they are also mothers and grandmothers and young single women who want to have a social life, and these are the things that drive them out of nursing and out of practice.

I would like to say that discrimination is very much engrained in our system, and I mean female discrimination. The nursing profession has been one of the people to suffer the most since we are primarily women.

Thank you, sir.

Senator CRANSTON. I would like to stress that my bill seeks to emphasize and develop opportunities for upward mobility for nurses, for opportunities for them to assume greater responsibilities. I think some of the practices that have held down nurses from expanding their opportunities are the results basically of a sexist attitude toward them. As you mention, most of them are female, and the term "nurse practitioner," as I understood it, is intended to provide this opportunity for more responsibility. I would like to know if you have reservations about that.

Miss COLEMAN. No, indeed. I feel that one of the reasons for the health crisis today is that nurses have not been allowed to utilize the knowledge that they have had for quite some time, and I think that this has come about because of legal restrictions on what is medical practice and what is nursing, and that now Government is beginning to take a look at the picture. However, I do feel that medical organizations and hospital organizations are making statements without consulting the Nursing Association, and I feel that since we are the largest single body to give care to patients and to deliver care, that this can't be complete up-to-date information and that ANA has got to be involved and the AMA and make their statements.

Senator CRANSTON. Yes. I would like to ask one question of you. Mr. Zembower, you have not given any comments on S. 2219 which would provide for the expansion of Veterans' Administration health manpower training programs and the establishment of new health professions schools, including nursing schools based at Veterans' Administration hospitals. I think this bill offers substantial possibilities for increased and improved training of nurses, and I would welcome your comments on it for the record if you don't want to comment on it at this point.

Mr. ZEMBOWER. Mr. Chairman, we took a similar position on a bill on the House side in which our position was that we favor the bill if it is intended that nurses would get their clinical training in the Veterans' Administration setting rather than say in a Veterans' Administration school of nursing. We are not in favor of Veterans' Administration schools of nursing; we are in favor of the nursing education being done in the universities and colleges and use facilities like Veterans' Administration for clinical practice.

Senator CRANSTON. That is what we understand the bill to do and intended the bill to do.

Mr. ZEMBOWER. Yes, we favor that concept.

Senator CRANSTON. Good.

Mr. ZEMBOWER. On the point that Miss Coleman was making I would like, sir, with your permission to introduce into the record a statement that was made in the American Journal of Nursing in July of this year. It is a statement on the profession of unlimited potential and it is written by Nathan Hershey who is the president-elect of the American Hospital Association's Society of Hospital Attorneys. It is a very interesting article.

Senator CRANSTON. Fine. We would like to have that in the record.

(The above-mentioned article follows:)

[From the American Journal of Nursing, July 1971]

OPINION

PROFESSION OF UNLIMITED POTENTIAL

(By Nathan Hershey*)

What is nursing? Much has been said and written about it, but perhaps the viewpoint of an outsider could give nurses a new and useful perspective.

I think that the most profound changes in nursing practice will come from increasing realization that nursing is not a single profession or discipline, but represents a wide—or even unlimited—range of potential service. All nurses know that nurses are working in as widely differing roles as an assistant to a physician-specialist in his office and a counselor to young people at a narcotic users' outreach facility.

Consider with me some of the matters related to the licensure of professional nurses and how the current licensing system affects what nurses may do. Every licensing law for professional nursing contains a definition. The definitions tend to be conceptual; they do not specifically list all the things that nurses may do. But whether implicitly or explicitly, the laws forbid nurses to diagnose and to prescribe or order therapy. Yet anyone who is familiar with what professional nurses actually do recognizes that diagnostic types of decisions are made by professional nurses, and nurses play a role, often a significant one, in determining the therapy to be used for individual patients. Then, too, there is much evidence that physicians are sloughing off certain kinds of activities and responsibilities. Considerable portions of what is being sloughed off are not recognized as being within professional nursing, yet much of it can be or is extremely rewarding work.

In the past few years we have witnessed the emergence of what has been called the physician's assistant, who is to provide extra sets of hands, eyes, ears, and so on to the physician. With this help, the number of people he serves can be increased and the level of care improved over what he could offer if he practiced alone. These persons can serve in a variety of settings, ranging from a rural facility in which there is no physician ordinarily present to a large outpatient clinic in a metropolitan area.

Some nurses I have encountered resist the idea that professional nursing should move to fill the gap in patient care that is beginning to be filled by the physicians' assistant. They view nursing as a separate and distinct discipline and hold that service as a physician's assistant does not call for the skills and qualities that characterize professional nurses.

Perhaps they are right, and yet nursing education prepares nurses to be generalists in much the same way the physician at medical school was trained as a generalist. Should not individual nurses have the freedom if they so desire, to opt for service as an assistant to physicians in primary care situations and to perform procedures and make decisions traditionally recognized as within medical practice? This role for nurses would seem to demonstrate the interdependence of nursing and medicine. I should not like to see a decision by some of the leaders of professional nursing that this kind of service is unworthy of people educated as professional nurses and legal and other blocks placed in the path of nurses who do not agree with these leaders. I should add that the economic rewards for service as what is termed a physician's assistant exceed those afforded most professional nurses, except those with high posts in administration or education.

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*Mr. Hershey is professor of health law, Graduate School of Public Health, University of Pittsburgh, Pa. He has recently been elected president-elect of the American Hospital Association's Society of Hospital Attorneys.

Then there is the question of licensure. If physicians' assistants were recognized as members of a new profession or occupation, with its own structure comparable to that of professional nursing, under a mandatory licensure law, the net effect might be to exclude professional nurses from kinds of primary care callings that might be very attractive to some of them or require them to obtain additional education, parts of which would be unessential or redundant.

I have advocated an end to licensure for all kinds of health personnel who work as employees of or—like the private duty nurse—on referral from physicians and licensed health care institutions. In this way we could avoid creating artificial barriers to the employment of skills and capacities that can be developed through additional formal and informal education and experience. I don't want to see nurses hemmed in by legal definitions. The greater the horizontal and vertical mobility for health personnel, the more responsive the health care system can be to public needs and demands.

Limitations on what nurses can do are built into the basic licensure process. These limitations may be more or less strict than is appropriate, when one takes into consideration the education and experience of individual nurses. I believe that individual nurses develop their talents at different speeds and that some nurses in clinical settings reach levels of capacity beyond those reached, or even aspired to, by other nurses. And anything that puts a premium on meeting rigid requirements before increased education and experience can be capitalized on, inhibits both professional development and the improvement in the service provided patients.

One reason for my concern about the possibility that organized nursing may foster an almost impermeable barrier to professional nurses' working as physician's assistants is linked to the nature of nursing performance. From my experience as a patient, as an occasional observer, and from my reading, I gather that the supportive role of the nurse and personal interaction with the patient on something other than a strictly technical or mechanical basis is of great importance to a patient's well-being. I believe that the nurse who can bring this leavening into the relationship between the patient and the physician by serving as his associate or assistant, and while doing so engage in selected medical tasks and functions, can be a most important kind of health worker.

The pay check

In regard to the economic aspects of the professional nurses' situation, we note that the ANA and the state and district associations, to the extent they are involved in bargaining with employers of nurses over economic security matters, are very concerned with the basis monthly or yearly salary minimums. While this is not an unimportant issue for entrants into the field, for those who have made nursing a career or who plan to make nursing a career, economic rewards associated with the nature of the work or service performed as one moves up from the beginner level are of greater importance. The reason physician's assistants are able to leave the Duke program and move on within a year or two to incomes in the $12,000 to $15,000 range, is partly because they are looked upon as personnel who support and improve the practice of medicine, and not as nurses.

If a physician who had gross receipts from his practice of $100,000 employs a physician's assistant or associate and finds in the following year that his receipts have increased by a third, because many services can be provided to his patients, with no diminution in quality, by the physician's assistant or associate, it is not difficult to understand why he can afford, and is pleased, to pay $12,000 or more a year to the person who provides these services.

In nursing, traditionally, the best rewards have gone to those who have left clinical nursing and moved on into education and administration. Now, one cannot condemn decent salaries for administrators and educators. But is it not unfortunate that the nurse who brings considerable clinical ability to patient care is less well rewarded? Then there are those who view levels of education as an appropriate basis for distinctions in regard to remuneration. Is it not appropriate to view economic rewards for personal service, and nursing certainly is personal service, in terms of the importance of the service to the consumer, rather than in terms of the education the givers of service bring to their positions?

In some contracts between professional nurses and their employers, salary differences based solely on education are established. Some institutions are resisting this approach, asserting that their basis for salary differences is not necessarily related to educational attainment. This kind of differentiation creates a dilemma for nurses associations who purport to represent all nurses, yet are bargaining for a group which consists of different categories of individuals who will not be treated alike under the contract.

HEALTH SERVICES

There is ample evidence that there is considerable dissatisfaction with the way in which health services are provided. There is also clear recognition that the cost of health services is rising faster than the costs of other services and goods in our economy, mainly because of an increasing demand for services when the supply of services in the current mode of organization is not increasing as rapidly. Once the government has assumed a major responsibility for underwriting health care costs for those who cannot afford it, as it has already done to some extent, the available health services will be increasingly inadequate to meet the increased demand without changes in the health services system.

The position has been taken by some that major reasons for the excess of demand for health services over supply is more the result of improper or ineffective organization of the services with the existing personnel than an absolute shortage of personnel. Should not professional nurses have the opportunity to increase the range of their performance to meet both their own personal needs for satisfaction and the needs of the population for health services? Many of the responsibilities now restricted by law and custom to physicians are not being met for all members of the population in need of services because of the alleged shortage of physicians. If it could be demonstrated that these would be met by professional nurses, I cannot believe that many would resist the challenge to fill the gap. I believe most nurses do not want to get into sterile arguments over whether particular kinds of activities are or are not professional nursing, as long as their education and experience has prepared them to carry out those activities safely.

There are counties in many states in which there is not a single physician. Primary care is dispensed in such an area by volunteer first-aiders and by members of the immediate family. When a serious problem develops, the sick or injured individual is transported a considerable distance by automobile or ambulance to a hospital or other health care facility where physicians are available. There might not be a sufficient volume of medical practice ever to support a physician in such areas. However, it might be possible to set up a small dispensary, headed by a nurse with a small amount of additional training over traditional nursing education. That nurse could meet many of the health care needs of the population on a considerably higher level than can be offered by volunteers and members of the immediate family.

There could be a direct telephone or another communications link to a hospital at which physicians are constantly available. However, it would be recognized that the nurse would be able to handle some cases without physician consultation. He or she would exercise discretion based upon education and experience and in line with guidelines and procedures established by physicians and nurses together. Such services already exist in this and other countries.

Last summer I met with nursing leaders in a southern state who wanted to develop changes for their state's nursing practice act. After several hours of discussion, the leadership of the state nurses association agreed on the basic elements of a legislative proposal under which individuals with nursing education would be recognized under the law as individuals with "unlimited potential" for providing health services. Nothing would be deemed automatically beyond the scope of their practice, and each such person would be legally permitted to give health services in accordance with the qualifications he or she could demonstrate. The nurses present recognized that if this proposal were to achieve legislative recognition, the terms "nurses' and "nursing" might have mainly historical interest, because they would describe neither the persons nor the field indicated by the concept of "unlimited potential."

The next morning we met with several state legislators who seemed flabbergasted that organized nursing in the state would propose such a concept. They were also pleased.

No one who has had dealings with legislatures believes that they work expeditiously. But the radical proposals of one year may be adopted after several years have gone by for study and reaction to them. After a few years they are not so radical.

DIVERSITY, INNOVATION

In summary, then, I look to nursing to encourage diversity that will permit individuals to seek out various paths for personal career satisfaction and that will, at the same time, facilitate the provision of services to those seeking health services—services that will be recognized as necessary in the future, as well as those offered now. I look to nursing to decide not to write off areas of activity because they have traditionally been domains of the physician; to recognize that the economic facts of life may militate in favor of different approaches to compensation from those so far manifested; to encourage innovation in nurse education, through sharing classes with medical, dental and pharmacy students even if it means relinquishing some of nursing's exclusive control over nursing curricula.

Mr. ZEMBOWER. I would also like to say in regard to the pay system that ANA supports the rank-in-man pay concept that we use in the Veterans Administration to pay professionals. This pay system encourages professional development and the improvement in the service provided patients. While we favor the rank-in-man, we do not favor the rank-in-"man" and we feel that this might be an aspect of the pay system which is proposed in S. 2354. We know that you would not like to do that on purpose.

Senator CRANSTON. It would be very helpful to the committee if you could provide—if you don't have it right here at your fingertips—for the record as fully as possible data showing the situation for nurses under the Civil Service, under the Department of Defense, and in various communities of the major regional sections of the country in the categories covered in table 3 of your prepared statement dealing with premium pay benefits for nurses. I would also particularly appreciate that information broken down for the State of California.

Mr. ZEMBOWER. I would be glad to do that. The California State Nurses Association is a big help in gathering information, this same kind of information, for the Civil Service Commission.

Senator CRANSTON. Fine. Thank you very much. It is very helpful to have you with us and we will be paying full attention to your viewpoint and your needs.

Mr. ZEMBOWER. Thank you.

(The information subsequently supplied follows:)

PREMIUM PAY BENEFITS IN SELECTED ANA COLLECTIVE AGREEMENTS, SEPTEMBER 1971

Name of facility	Normal workday (hours)	Normal workweek (hours)	Overtime rate	Shift differential	On-call pay	Call-back pay	Basic salary [1]
City of Hope, Duarte, Calif.	8	40	1½ times	Evenings $65 month; night, $60 month.		Guaranteed 4 hours overtime.	$636 month to $1,060 month.
Seattle, Wash., area hospital council [2]	8	40	do	Evenings, $40 month, night, $35 month.	$3 to 5 per 8 hours	Guaranteed 3 hours over time.	$673 month to $774 month.
Community General, Sullivan County, New York	7½	37½	do	$37.50 month	$7.50 each 8 hours		$577.05 month to $795.80 month.
St. Elizabeth's, Utica, N.Y.	7½	37½	do	12 percent of base pay	$8 per night		$6,786 to $10,900.
Ellis Hospital, Schenectady, N.Y.	8	40	do	10 percent	$12 night operating room		$7,500 to $11,024.
University of Chicago	8	40	do	$3 evenings and Sund-; $6 night.	Base rate		$675 to $921.
County of Los Angeles			do	45 cents per hou	$5	Guaranteed 4 hours over time.	$776 to $1,540.
Jewish Hospital and Medical Center, Brooklyn, N.Y.	7½	37½	do	$1,500 per year	(3)		$10,760 to $12,810.
County of Sacramento	8	40	do	(4)	(5)		(6)
Kaiser Foundation and Permanente Group	8	40	(7)	(8)	(9)		$750 to $905.

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[1] Minimum and maximum salary of all nurse levels covered by agreement.

[2] 20 hospitals in council.

[3] $25 for each weekday shift and $30 for each weekend shift of 16-hours.

[4] $50 month between 12 noon to 6 a.m.

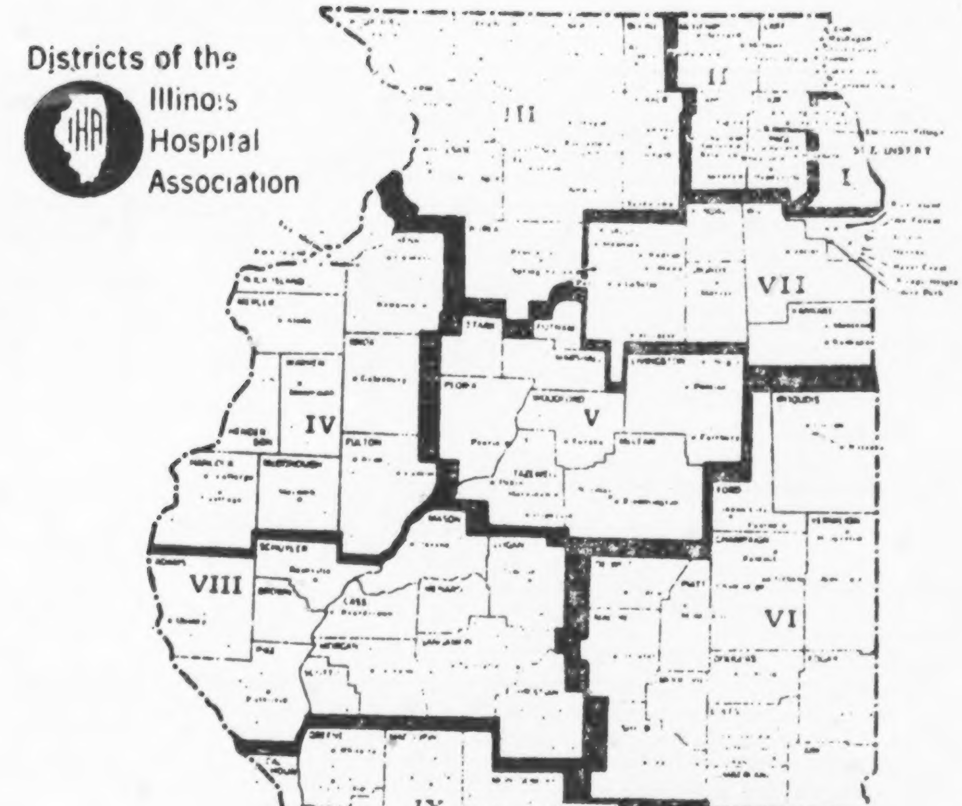
[5] 2-hours pay for each 8-hours standby.

[6] Not available.

[7] 1½ time-over 8-hours or 40-hours. 2 times for 7th consecutive day.

[8] 379 per hour between 2 p.m. and 6 a.m.

[9] Holiday standby for O.R. nurses ¾ths standard time. Other standby, compensable time or ½ times standard time.



Districts of the Illinois Hospital Association

TABLE 2.—GENERAL DUTY NURSES—PREMIUM PAY FOR EVENING SHIFT COMPARATIVE BY DISTRICT, AVERAGE MONTHLY PREMIUM PAY FOR 3 TO 11 P.M. SHIFT (STATE AND FEDERAL HOSPITALS EXCLUDED)

District	Number of hospitals	Hospitals giving premium pay		High	Low	Average
		Number	Percent			
I	64	60	93.7	$125	$25	$89
II	23	19	82.6	125	20	59
III	17	11	64.7	136	20	39
IV	13	13	100.0	75	10	79
V	10	7	70.0	55	22	41
VI	21	19	90.5	75	10	87
VII	14	11	78.5	95	10	55
VIII	12	12	100.0	65	15	79
IX	16	16	100.0	45	15	69
X	27	20	74.0	55	10	52
XI	153	128	83.6	136	10	64
Total, State	217	188	86.6	136	10	72

Source: Hospital Salaries in Illinois, 1970, Illinois Hospital Association.

AMERICAN NURSES' ASSOCIATION, INC.,
New York, N.Y., January 7, 1972.

Senator ALAN CRANSTON, Jr.,
New Senate Office Building,
Washington, D.C.
(Attention Ms. Louise Ringwalt).

DEAR MRS. RINGWALT: I have gathered some examples of on-call or standby pay practices in several locations in the Nation to support and justify the 25% on-call pay we have recommended to the Senator for inclusion in S. 2354. I have not identified the employer by name, just the state in which the hospital is located. I have taken these examples at random without attempting to extract only the best.

CONNECTICUT

Example 1.—On-call pay:

25% for time on-call. If called, paid straight-time.

Weekend non-overtime pay, 10% additional.

Example 2.—On-call: Operating Room Nurse:

$15.50 for each on-call period of 16 hours.

$5.00 for each 8 hours.

When called paid 35¢ per hour extra on weekends when taking call and called in to work.

Example 3.—O.R. Nurse on-call: Recovery Room Nurse.

First call $1.60 per hour for all time on shift of call.

Paid regular rate when called to work for time worked.

Second call. $5.00 per shift.

MONTANA

Example 1.—On-call:

$25.00 per month in addition to specified salary. When called paid overtime rate.

Weekend: If required to work more than 2 shifts ending on a Sunday in a 4 week period the nurse is paid 40¢ per hour extra for all hours worked on 3rd and 4th shifts ending on a Sunday. This is interpreted to mean that a nurse who is required to work three or four weekends, which have been consecutive, gets the premium rate.

Example 2.—On-call:

$2.00 day from Monday through Friday.

$5.00 day Saturday and Sunday.

Example 3.—On-call:

$4.00 per day.

Example 4.—On-call:

$.40 per hour while available for work and time and one-half for actual work.

NEW YORK

Example 1.—O.R. Nurse, On-call:
$5.00 for taking night call, i.e., being available for call overnight.
Straight salary, if called.
Example 2.—On-call:
$10.00 for each 16 hour weekday shift.
$15.00 for each 16 hour weekend shift.
Example 3.—On-call:
$12.00 for each 8 hour weekday shift.
$13.70 for each 8 hour weekend shift.
Example 4.—On-call: O.R. and Ob-Gynecology:
$12.00 for 16 hour period. If called, time and one-half regular salary plus prorated part for any specialty differential.
Example 5.—On-call:
¾ths of regular rate for each 16 hour shift.
If called, guaranteed not less than 4 hours pay at premium rate.

ILLINOIS

Example 1.—On-call:
$2.31 for each hour of call.
Example 2.—On-call to arrive within 20 minutes of notification:
Compensated at base rate of individual.
Example 3.—On-call:
Guaranteed 3 hours at time and one-half.

HAWAII

Example 1.—On-call:
After a full day's work .85 cents per hour for each hour on-call. If called, guaranteed 1-hour of work or pay at 1½ times regular rate.
Example 2.—On-call:
$6.80 for each period up to 8 hours.
$13.60 for period of from 8 to 16 hours.
$20.40 for period in excess of 16 hours.

You can see that on-call pay practices vary considerably from one location to another. But one thing is certain, there is enough evidence here to justify establishing an on-call pay practice in the VA. We have been supporting the Moss bill in this respect and still do.

For example, a nurse working in the operating room, recovery room, intensive care or coronary care units are the employees subject to on-call status. Presently these nurses are regulary given on-call assignments. This is a regular routine occurrence especially in the operating rooms. There is no compensation. A VA nurse is considered as being paid on an annual basis and ready for duty around the clock, the same as a military nurse. Under Senator Moss' proposal in S. 1635 a nurse taking call would be paid 25% of her 8 hour rate for this duty.

Example: Full grade nurse, step 4 rate of pay; $12,150.
2080÷12,150=$46.72 daily rate
$46.72×25%=$11.68 on-call rate for 8 hour period as proposed in S. 1635.

One example, from New York, shows that $12.00 per 8 hours is paid during week and $13.70 for weekend shift. In Illinois, one example shows where $2.31 for each hour of call is paid. In the chart that I sent at your request in September, there are examples of the on-call rate amounting to $1.00 per hour. In the Jewish Hospital and Medical Center, Brooklyn, New York, we find that $25.00 is paid for each 16 hour period of call during the week and $30.000 for each 16 hour weekend shift.

I have stated that the occurrence is frequent in the VA. I have no statistics to give you on this but I am trying to gather some definite information for you. I am not able, at this time, to say when the study will be completed.

I believe that there is ample justification for the 25% on-call rate. I hope that when the Committee reports out a bill that this feature will be part of it.

Sincerely,

Patrick E. Zembower,
Associate Director in charge of Federal Representation.

Senator Cranston. Our final witness is Mr. William Samuels, executive director, Association of Schools of Allied Health Professions.

Mr. Samuels, thank you for being here. Thank you for waiting.

STATEMENT OF WILLIAM SAMUELS, EXECUTIVE DIRECTOR, ASSOCIATION OF SCHOOLS OF ALLIED HEALTH PROFESSIONS

Mr. Samuels. You have received a copy of my statement previously. If you would like to waive the reading of it and direct questions to me as a means to save time, that would be most satisfactory with me.

Senator Cranston. That is fine.

(The statement of Mr. Samuels follows:)

Statement of William Samuels, Executive Director, Association of Schools of Allied Health Professions

Mr. Chairman and members of the Subcommittee. I am William M. Samuels, the Executive Director of the Association of Schools of Allied Health Professions. The Association's National Office is located in Washington, D.C. On behalf of our membership I wish to express our appreciation for being invited here today to present this statement concerning training of allied health professionals within Veterans Administration system of clinical facilities. The Association represents allied health education at the 2-year junior/community college level, the 4-year baccalaureate and graduate school levels, and in the teaching-clinical facilities, including Veterans Administration Hospitals. Therefore, our membership is representative across-the-board of higher education and is most interested in all proposed legislation relating to the training of allied health professionals and especially in the proposed education-related bills being considered here today.

This statement, however, is limited to those areas dealing directly with allied health education inasmuch as it would be most inappropriate for me to discuss the needs and desires of the health disciplines of medicine, dentistry, pharmacy, and portions of nursing. The Allied Health Professions represent the bulk of the other health disciplines involved in the delivery of health care.

The Association membership is most interested in sub-chapter four of Senate Bill 2219 calling for federal assistance to affiliated schools, including schools of allied health. Such an approach, if properly structured and funded, very well could help expedite the delivery of health care nationally as it currently is being sought at the various levels within the federal government.

Training programs in the United States have been identified for more than 150 allied health fields. At this time there are 885 colleges and universities involved in higher education of allied health professionals at the baccalaureate degree or higher and many of these schools already have some kind of affiliation agreements with neighboring Veterans Administration facilities. Additionally, there are over 1,000 community/junior colleges with programs in allied health education at the Associate Degree level and an estimated 2,000 clinical facilities also offering training in allied health programs ranging from a few months to several years of study.

All of these programs are interested in meeting the demands pressed upon the nation's deliverers of health care by training of qualified professionals in the new technologies. However, rising costs very well could mean a loss of some of these successfully proven, now ongoing programs that already are turning out qualified professionals whose skills are vitally needed if we are to maintain a healthy citizenship nationally. This is why we feel the Veterans Administration Health Manpower Training Act of 1971 could be a vital link to both this national interest and to the allied health education.

The health legislation of the past has given very little attention to the allied health fields. The only important federal legislation for allied health was five years ago with the enactment of the Allied Health Professions Training Act of 1966. Because of a great number of new programs that have developed at all educational levels in response to filling the need for more manpower the effect of this legislation has been a lower level of funding of individual programs.

A required segment of most allied health education is the clinical practice within an allied health facility. One of the major constraints to the development of an allied health educational program has been the tremendous need for clinical sites for these programs. The need is equally critical for both community college and university programs as the lack of available clinical facilities reduces the number of students that can be admitted into the educational programs.

Additionally, instructional space always has been at a premium and when you are among the late-comers in education you can expect to be low on the priority scale for space allocation. Unfortunately this is true in a majority of the major educational institutions insofar as allied health educational programs are concerned.

Another serious roadblock in the development of any new professional or occupational career is the absence of a well qualified cadre of instructional personnel. Teacher preparation in allied health education already carries a high priority and due to a lack of federal support for teacher preparation the Kellogg Foundation has established four major centers for training of teachers in the allied health areas for both university and community college programs. These centers are at the University of Kentucky, the University of Florida, the University of Illinois, and the State University of New York at Buffalo. But this is only a start and more centers are needed. It is our belief that program support, instructional space, and teacher preparation can be enhanced by proper support from the federal government. The use of Veterans Administration hospitals in affiliation with community colleges and four-year colleges could be one step to help bridge a gap of program support, instructional space and teacher preparation that now exists in the training of allied health professionals. By and large, we are talking about programs that can be implemented without the need of construction funds and in areas with clinical space and with qualifying instructional personnel. Affiliation agreements between educational institutions and Veterans Administration hospitals—if properly supported—can be implemented with a minimum amount of effort and results could be realized within a very short period of time.

Recognizing that there is a limitation on the dollars this nation can spend on health, I am confident that with an appropriation authority the Veterans Administration in working *with* educational institutions can serve as a realistic model for other community hospitals. Building on the utilization of the strength of the Veterans Admnistration system including hospitals, manpower, and space, I feel sure that this could take us a step nearer to the achievement of our health goals for society. Those of you who share the responsibility for such decisions hopefully will take the necessary action to implement this measure to improve the allied health training programs in our nation. I will be most happy to answer any questions the chairman or the committee members may have on this or other Veterans Administration legislation you are now considering, as it would relate to allied health education.

Senator Cranston. Do you have anything particularly you want to say?

You have been here, I think, most of the time. Do you have any comments to add to your prepared statement or the testimony we received?

Mr. Samuels. No, sir, except the association is supportive of Senate bill 2219. We feel the affiliation of clinical facilities, such as the Veterans Administration hospitals, with the community college and 4-year college programs is needed and that a good, well-structured affiliation could be an answer, especially in the allied health professions.

Senator Cranston. Do you feel that analogous to the health professions schools needed, it would be helpful to develop new allied health schools in affiliation with Veterans Administration hospitals?

Mr. Samuels. You mean separate Veterans Administration allied health schools?

Senator Cranston. Not Veterans Administration schools but schools making full utilization of Veterans Administration clinical facilities for training.

Mr. Samuels. We would not favor separate Veterans Administration allied health schools. We favor a partnership arrangement with the clinical facilities.

Senator CRANSTON. Yes.

Mr. SAMUELS. Right.

Senator CRANSTON. You feel that would be constructive?

Mr. SAMUELS. Yes, sir, very much.

Senator CRANSTON. I will be particularly interested in reading your testimony because I think the development of more and new types of allied professionals is one of the most important contributions that can be made to the health system.

Mr. SAMUELS. Thank you. We feel the same way.

Senator CRANSTON. We must deal with the problems of the lack of manpower if we are to be effective in dealing with the cost of rendering service.

Thank you very much. I appreciate your cooperation in summarizing so I can get to the health manpower conference.

Mr. SAMUELS. Thank you.

Senator CRANSTON. Thank you.

Without objection, at this point in the record, I order to be printed all prepared statements and other pertinent materials subsequently submitted for the record.

These hearings now stand adjourned.

(Whereupon, at 3:30 p.m., the Senate Subcommittee on Health and Hospitals of the Committee on Veterans' Affairs was adjourned.)

(The material referred to above follows:)

STATEMENT OF HON. JOHN G. TOWER, A U.S. SENATOR FROM THE STATE OF TEXAS

Mr. Chairman, I want to thank you for allowing me the opportunity to present this testimony on behalf of two bills which I have introduced: S.J. Resolution 128, the "Veterans' Administration Medical School Assistance and Health Service Personnel Education and Training Act of 1971"; and S. 2304, the "Veterans' Allied Health Professions Training Assistance Program."

During the past decade, Americans have become increasingly concerned with the quality of medical care. Scientific, technological, and medical research have created entire new concepts and fields of treatment; Federal legislation has made it financially possible for many people who previously could not afford treatment to obtain it; and a more knowledgeable general citizenry has increased the demand for adequate medical treatment, which has seriously strained the ability of our health care system to effectively and efficiently render such treatment.

As responsible members of the Senate, we must carefully examine the complexities of the problems which presently affect our national system of delivering health care. Although it is essential that the federal government participate in programs designed to correct these problems, we must proceed with caution in order that the federal government's input will not come to dominate the system.

Our emphasis should be placed on quantity, for one of the greatest shortcomings in obtaining an adequate level of quality is the lack of sufficient facilities and manpower. The federal government, through such legislation as the Hill-Burton Act, has done an admirable job of providing the necessary facilities. The Veterans' Administration is constantly constructing new hospitals in an effort to provide veterans with needed medical care. Although such facilities are impressive, however, they are meaningless if we are unable to properly staff these hospitals with an adequate number of qualified medical personnel. In view of the distressing national shortage of health manpower, which is conservatively estimated to be over 50,000 doctors of medicine and over 250,000 allied health and other medical personnel, it is imperative that we take immediate action to promote the establishment and expansion of health training programs. It is for this reason that I have introduced S.J. Resolution 128 and S. 2304.

I was greatly encouraged by recent Senate action in relation to the Comprehensive Health Manpower Training Act of 1971 and the Nurse Training Act of 1971. I am confident that this action will ensure the continuation of the fine legislation which has accomplished so much in these areas in the past. But to say that we have done all that is necessary to eliminate the health manpower shortage would be incorrect. The need is so acute and the time so short, that to do less than completely utilize such an appropriate and invaluable national resource as the Veterans' Administration Department of Medicine and Surgery would be not in the best interest of the nation.

I commend Representative Teague, Chairman of the House Veterans' Affairs Committee, for his outstanding work on H.J. Resolution 748, which is identical to S.J. 128. This bill would greatly enhance the ability of the Veterans' Administration to train qualified health manpower in cooperation with its affiliated institutions.

The following facts demonstrate the potential of this legislation:

1. The Veterans' Administration operates the largest medical care system in the United States, and perhaps in the world. It presently has more than 165 hospitals geographically dispersed throughout the nation, with a potential capacity of 97,000 beds.

2. The Veterans' Administration's Department of Medicine and Surgery has made a substantial contribution in the field of health education. For over 25 years, hospitals of the Veterans' Administration have been offering hospital-based educational experience in collaboration with most of the nation's medical schools.

3. Veteran's Administration hospitals are currently affiliated with 81 medical schools, 51 dental schools, 287 nursing schools, 274 universities, and 84 community and junior colleges.

4. During the current fiscal year, more than 50,000 students will participate in more than 60 categories of training in VA institutions. Because of the size, diversity, experience, and quality of its medical facilities and training programs, the Veterans' Administration's Department of Medicine and Surgery is uniquely qualified to undertake the programs outlined in S.J. Resolution 128 and S. 2304. We cannot afford to squander the expertise and experience of the Veterans' Administration in this area which is so vital to the national interest.

At this time, I would like to briefly detail the provisions of S.J. Resolution 128. It would create a new chapter (82) to title 38, the United States Code, to be entitled "Assistance in Establishing New State Medical Schools: Grants to Affiliated Medical Schools: Assistance to Health Manpower Training Institutions." The chapter is divided into three subchapters, each of which is designed to accomplish certain designated programs.

Subchapter I would provide a pilot program of assistance in the establishment of not more than five new State medical schools to be located in proximity to, and operated in conjunction with, Veterans' Administration medical facilities in geographically dispersed states. The assistance would include (1) leasing of VA land and buildings to the State, (2) remodeling and repair of VA structures to render the buildings suitable as educational facilities, and (3) grants (on a reducing basis) to reimburse the state for faculty salaries. A fine example of how successful such a program could be has been demonstrated by the medical school established in Shreveport, Louisiana by the State of Louisiana and Louisiana State University. Early in 1967 arrangements were finalized whereby the medical school would be granted the use of surplus space in and on the compound of the Shreveport Veterans' Administration Hospital. Soon thereafter, the core administrative staff and faculty moved into the hospital. In the fall of 1969, only 14 months later, 32 students were admitted to the first class. Another 32 students were admitted to the class of 1970, while 40 will be admitted for the class of 1971. The total cost in terms of renovation and rent to date is $168,000. Contrast this with the creation of 16 other medical schools from 1960 to 1966, which exhibited a time lapse of five and one half years from authorization to actual enrollment, and a combined total cost of $1 billion. This proposal is an extension of the project in Shreveport. Within a reasonable period of time, with a modest appropriation of funds, we can significantly increase our nation's capability to produce qualified physicians.

Subchapter II would authorize the Administrator to establish a program of grants, on a matching basis, for medical schools which have maintained an affiliation with the Veterans' Administration. These grants would assist such schools in carrying out projects and programs for the improvement and enlargement of their facilities. They would make a significant contribution to strengthening the medical education program of the schools, with the result of a substantial increase in the number of students able to attend medical school. This chapter is designed to enable medical schools to increase their enrollment and modify their curriculum in an effort to fully develop the potential resources of the health professional training programs which presently exist.

Subchapter III would authorize the Administrator to initiate a program of grants, on a matching basis, in order to establish cooperative programs for the development and evaluation of new health careers and the improvement in utilization of allied health manpower. This proposal would promote the creation and expansion of new health careers such as the "physician's assistant." Presently, the VA is involved in physician's assistant training programs only to the extent that some of its hospitals offer the use of their clinical resources to affiliated academic institutions. VA hospitals are affiliated with 8 different programs which qualify their graduates under the Civil Service standards for physician's assistants. I am proud of the fact that one of these programs is being initiated by the Baylor College of Medicine, which is a clinical affiliate of the VA Hospital in Houston, Texas.

The total authorization level for S. J. Resolution 128 would be $33 million for the first fiscal year and $34 million per year for the following six years. In addition, it contains the necessary provisions to ensure that the funds will be distributed and utilized in a responsible manner.

One of the most immediate benefits to be derived from the initiation of these proposals would be an increase in the quality of medical treatment in VA hospitals. The long-range benefit, however, would be an increase in the number of qualified medical personnel available for employment by the Veterans' Administration and utilization by the entire nation.

Mr. Chairman, I would now like to proceed to a discussion of S. 2304, the "Veterans' Allied Health Professions Training Assistance Program." I would like to thank my fellow Senators who have joined me as cosponsors of this bill. They include Senator Cook, Senator Hansen, Senator Stevens, Senator Talmadge, and Senator Thurmond of the Senate Committee on Veterans' Affairs as well as Senator Baker, Senator Bennett, Senator Brock, Senator Cooper, Senator Dole, Senator Hollings, Senator Inouye, Senator Mathias, Senator McGovern, Senator Moss, Senator Percy, and Senator Young. I appreciate the concern they have shown by supporting me in my efforts to secure the passage of this much needed legislation.

DEFINITION OF ALLIED HEALTH MANPOWER

The Bureau of Health Professions Education and Manpower Training of the Department of Health, Education, and Welfare defines "allied health manpower" as "those professional, technical, and supportive occupations in the fields of medical care, community health, public health, and environmental health services whose activities support, complement or supplement the professional functions of the medical doctor, osteopathic physician, dentist, and professional nurse."

GROWTH OF ALLIED HEALTH PROFESSIONS

The allied health professions constitute a significant number of persons who perform a wide range of functions in the delivery of health service. Allied health workers in medical, dental, and environmental health fields in 1970 totaled about 925,000 and when added to more than 1.2 million nursing auxiliaries (which includes licensed practical nurses, nurse aides, orderlies, and attendants) make up more than half of all 3.9 million persons employed in health occupations. By 1975, it is estimated that only one third of the medical work force will consist of the traditional health team of physician, dentist, and nurse. The remainder will consist of over 200 different kinds of professional, technical, and vocational workers in allied health fields. The development of trained allied health manpower in a variety of occupations, optimally distributed and fully utilized is an ingredient critical to the efficient and effective delivery of health service.

POSSIBLE SOURCES OF MANPOWER RECRUITMENT

It is now generally agreed that the total need cannot and should not be met solely by programs designed to recruit and train individuals who are novices to the health field. A significant part must be supplied by improving the utilization of people already employed in the health field and by attracting to these occupations many men and women who, though well-qualified, are now discouraged or effectively excluded by formal academic requirements. The military "medic", who is returning to civilian life, is an example of a trained member of the health care team who is not being successfully encouraged to remain in health related fields.

RESOURCE POTENTIAL OF THE MILITARY "MEDIC"

Student Selection: The Armed Services carefully screen the personnel to determine their potential in health occupations. The selection process consists of evaluating the individual's scores on mental and physical tests, his civilian occupation and experience, his educational achievements, his stated preferences and the personnel needs of the Armed Forces.

Comparison of Military and Civilian Students: The course prerequisites for advanced medical training compare favorably with those required by health occupation courses at the associate of arts level in community colleges. In fact, a survey conducted by Colonel James J. Young, U.S. Army, indicated that most of these individuals exceeded the established Army pre-requisites. Furthermore, the study indicated that a large percentage of these individuals had one to two years of college.

Military Training Programs: The Armed Services, in order to meet their health manpower needs, conduct extensive training and education programs. I will limit my remarks to the efforts of Army because it trains more people in a greater variety of specialties than the other services. In the face of the large influx of untrained personnel and the high turnover rate of inductees, the Army Medical Department must devote a significant portion of its human and physical resources to the education and training of enlisted allied health manpower.

This education and training is accomplished through several educational mechanisms: formal school courses, apprenticeships, and on-the-job training. Often, a course is a combination of these various mechanisms. Most courses are well established and have been repeatedly revised and reviewed over the past ten years. These courses are conducted by highly qualified personnel who are carefully selected on the basis of their expressed desire, demonstrated ability, experience, and competence in their respective fields.

The fact that the accepted professional certifying bodies have recognized a number of these military occupational specialties is further evidence of the quality of the Army's training and education programs. Among the military occupational specialties so recognized are the X-ray specialist, the medical laboratory specialist, and the clinical specialist.

Army Medical Occupations for Enlisted Men: At this time, I want to include a complete listing of the Army's occupational specialties in the allied health fields:

Medical Equipment Repairman
Brace Specialist
Dental Removable Prosthetic Specialist
Optical Laboratory Specialist
Dental Fixed Prosthetic Specialist
Medical Records Specialist
Medical Supply and Parts Specialist
Medical Corpsman
Medical Specialist
Clinical Specialist
Operating Room Specialist
Dental Specialist
Psychiatric Specialist
Social Work/Psychology Specialist
Orthopedic Specialist
Physical Therapy Specialist
Occupational Therapy Specialist
Electroencephalograph Specialist
Electrocardiograph-Basal Metabolism Rate Specialist
X-ray Specialist
Pharmacy Specialist
Food Inspection Specialist
Preventive Medicine Specialist
Veterinary Specialist
Eye, Ear, Nose, and Throat Specialist
Medical Senior Sergeant
Medical Laboratory Specialist
Hospital Senior Diet Cook
Hospital Mess Steward Specialist

This list indicates the great variety of trained allied health manpower that the Army produces annually.

Size of Resources: The most important fact, however, is that each year it is estimated that 30,000 to 35,000 men and women, with medical skills and experience are separated from the Armed Services to enter the civilian labor force. While in the service, two thirds express a desire to stay in health careers, but only one third do so.

Conclusion: If the nation is as short of allied health personnel as recent studies would indicate, the nation's educational resources as meager as implied, and the cost of education as great as the record indicates, it is imperative that we should direct extensive efforts toward the effective use of these former servicemen in the civilian health community.

BARRIERS TO EFFECTIVE UTILIZATION OF THIS HEALTH MANPOWER RESOURCE

Based on extensive surveys, the following items were indicated to be significant barriers to employment in health careers by former servicemen.

Inability to meet certification requirements
Unrecognized military training
Insufficient education
Inability to work at level of skill
Low pay and fringe benefits
Little opportunity for advancement
Insufficient knowledge of health careers

I have not attempted to list these barriers according to their effectiveness in preventing military "medics" from entering the civilian health fields.

FEDERAL INITIATIVES TO UTILIZE RESOURCES

Task force on Allied Medical Education: In view of these barriers, the federal government has undertaken two significant programs. First, the Department of Defense is making a concerted effort to increase in-service training certification as a career incentive. The Air Force, Army, Navy, and American Medical Association have joined together as a task force to study the problems of certification and licensure of graduates of military training programs in an effort to erase some of these barriers.

The MEDIHC Program: Second, the Department of Defense and the Department of Health, Education, and Welfare, in a joint effort, have established the MEDIHC (Military Experience Directed Into Health Careers) Program.

The Department of Defense, through its Project Transition Offices, identifies, contacts, and counsels servicemen with military medical occupational specialties three or more months prior to discharge on civilian health careers education, and employment opportunities. Men interested in pursuing a health career complete an educational and experience background card to be sent to the designated State MEDIHC agency, which picks up on the counseling process and makes appropriate referrals to health employers and/or educational institutions.

The MEDIHC Program, as it develops, will be able to successfully assist these individuals who would otherwise be frustrated by a lack of knowledge of the available opportunities and the seemingly insurmountable obstacles to effective utilization of the skills they possess.

KEY TO FULL UTILIZATION IS EDUCATION

However, the vital key to eliminating these barriers is education. Education will enable these veterans to meet certification requirements. Education will enable them to work at levels commensurate with their skills. Education will enable them to enter health careers at levels with attractive wage scales and opportunities. This education will be specially designed to recognize their military training and experience.

A survey of the referrals received by the MEDIHC Program to date indicate that 26% wanted employment only and 5% wanted education only. Sixty-nine percent indicated that although they had to work, they wanted to continue their education at the same time. Seventy-four percent, in other words, have indicated that further education is essential to a fulfillment of employment aspirations in the health careers field.

THE PROPOSALS OF S. 2304

The "Veterans' Allied Health Professions Training Assistance Program" would provide medical training programs specifically designed for veterans with medical skills and experience acquired in the military. Such programs would utilize such devices as advanced standing and proficiency testing to enable the veteran to bypass unnecessary and repetitious training. These programs would supplement and complement their military training so that they could qualify under State and local law as allied health specialists in civilian communities.

The Administrator of Veterans' Affairs would distribute funds, in the form of grants, to medical training programs affiliated with the VA hospitals for the establishment and expansion of such designated programs.

The authorization level is $2,000,000 for the first fiscal year and $3,000,000 per year for the next six years.

CONCLUSION

If this nation is to facilitate the transfer of military-trained medical personnel to the civilian sector, we should initiate a program, such as the one contained in S. 2304, in the immediate future.

This program will directly benefit the veteran, especially at this time when the nation faces a high unemployment rate for Vietnam veterans. It will also benefit the Veterans' Administration by assisting it in its efforts to staff its hospitals with highly qualified personnel in the allied health fields, and it will benefit the nation by increasing the supply of trained medical personnel.

I feel that S.J. Resolution 128 and S. 2304 are far-sighted proposals which can effectively utilize the vast resources of the Veterans' Administration in our nation's efforts to train an adequate number of qualified health personnel to meet the demands which are being placed on our system of delivery of medical care.

Mr. Chairman and members of the Subcommittee: Thank you for the time and consideration you have given to this legislation.

STATEMENT OF HON. ERNEST F. HOLLINGS, A U.S. SENATOR FROM THE STATE OF SOUTH CAROLINA

Mr. Chairman, I appreciate this opportunity to be heard on S. 879, a bill which I introduced on February 19. S. 879 would amend chapter 7 of title 38, United States Code, to authorize the Veterans' Administration to provide hospital and domiciliary care to peacetime veterans who are unable to defray the expenses thereof.

I am confident that all of us would agree that our nation owes a continuing debt of gratitude to our citizens who have served with honor in the various branches of our armed forces. Obviously, our gratitude is no less in peacetime than in a time of armed conflict.

Unfortunately, there is an anomaly in our law whereby certain veterans' benefits are extended to those who have served in times of armed conflict but denied to those who served in times of peace. Under this law any veteran who served during a period of armed conflict is entitled to hospital and domiciliary care by the Veterans' Administration. These periods include World Wars I and II, and the Korean Conflict; in addition the "Cold War" since the Korean Conflict and Viet Nam are considered non-peace time periods. On the other hand, any veteran who served in the armed forces between World War I and World War II or between World War II and the Korean Conflict and who is under the age of 65, is denied care by the Veterans' Administration even though he is unable to defray the expenses of private care. The only exception is, of course, in a case where the need for such care is directly attributable to a service connected injury.

There are 275,000 veterans now living who served in the armed forces between World War I and World War II. There are presently 245,000 veterans who were in the service between World War II and the Korean Conflict. Obviously, some of these veterans have reached the age of 65 and others may also have served in World War II or the Korean Conflict; but the fact remains that there are many thousands who are under 65 and come within the "peacetime" category. Unfortunately, many of these thousands do not have the financial resources to privately seek proper medical and domiciliary care. This fact is underscored when we consider that the high unemployment has put many of these citizens out of work, that inflation has wiped out, or prohibited, substantial savings, and that age has placed many out of the job market.

In order to correct this anomaly and to give these veterans what is due them, I introduced S. 879. This bill would authorize the Veterans Administration to provide hospital and domiciliary care to peacetime veterans if they are unable to defray the expenses of such needed care.

Recently, a particular case was brought to my attention of a constituent of mine who was 62 years old, totally disabled and whose total income was $68.90 monthly from the Social Security Administration. Although he does have ½ acre of land which is devoted to tobacco, it is so heavily mortgaged that it does not produce any income. He presently has in excess of $2,300 in hospital bills and, although he requires further medical treatment, he is unable to finance such care. He served honorably with the United States Army in the 1920s but was told by the Veterans Administration that if he will just wait three more years, they will be able to assist him.

I believe that the arbitrary condition illustrated by this case and supported by our law ought to be changed. If the need is there and the circumstances warrant it, such care ought to be provided to all veterans regardless of age and regardless of the dates when they served.

Again, Mr. Chairman, I appreciate this opportunity to be heard and I urge favorable consideration of this legislation.

STATEMENT OF E. H. GOLEMBIESKI, DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman: We appreciate your holding the record open to permit submission of our statement on the bills under consideration. Circumstances on August 4 did not permit personal presentation of our position on them.

In general, the bills pertain to Veterans Administration health manpower training and salary and medical care.

Those relating to VA health manpower training include authorization for VA funds to establish pilot programs to establish and locate new State medical schools in proximity to and in conjunction with VA medical hospitals. Some of these bills also would authorize the Administrator of Veterans Affairs to provide matching grants to medical schools affiliated with Veterans Administration hospitals to assist them in improving and enlarging their facilities. In addition, they would further expand the role of the VA Department of Medicine and Surgery in training of medical and allied health personnel. Included in some of the bills are provisions that would further liberalize and expand eligibility for care in VA medical and hospital facilities, and to provide for direct admission to nursing care beds.

The remainder of my statement is directed to several of the measures before your Subcommittee.

S.J. Res. 128 (H.J. Res. 748 approved July 19, 1971 by the House of Representatives)

This joint resolution would authorize the Administrator of Veterans Affairs to provide certain assistance in establishment of new State medical schools; the improvement of existing medical schools affiliated with the Veterans Administration; and develop cooperative arrangements between institutions of higher education, hospitals, and other public or nonprofit health service institutions and the Veterans Administration to develop and conduct educational and training programs for health care personnel.

The resolution would amend 38 USC to authorize that there be appropriated $15,000,000 for the fiscal year ending June 30, 1972, and a like sum for each of the succeeding six fiscal years. Such appropriated sums are to be used to fund a pilot program under which the Administrator may provide assistance in the establishment of new State medical schools located in proximity to and operated in conjunction with VA medical facilities.

Subchapter I would authorize the Administrator to enter into agreement with any State to provide the following assistance—

1. Leasing of such land, buildings, and structures under the control and jurisdiction of the Veterans Administration as may be necessary for such school;
2. The extension, alteration, remodeling, or repair of buildings and structures;
3. Payment of grants to reimburse the State for school faculty salary ranging from 90 percent during the first twelve-month period of operation to 10 percent of such cost during the sixth such period.

Agreements under this subchapter are limited to the close of the seventh calendar year after the effective calendar year, and to the establishment of not more than five new medical schools, and that such schools shall be in geographically dispersed areas.

Subchapter II would authorize the appropriation of $15,000,000 for a similar seven-year period for matching grants to medical schools affiliated with the Veterans Administration to assist such schools in part to carry out projects and programs for the improvement and enlargement of their facilities.

Applications for grants under this subchapter may be approved only upon the Administrator's determination that—

1. The proposed projects and programs for which the grant will be made will make a significant contribution to strengthening the education program of the school and will result in a substantial increase in medical student attendance;
2. Assurance is given that any federal funds made available will be matched by funds from other sources.

A grant under this subchapter with respect to any projects or programs approved by the Administrator may not exceed 50 percent of the total costs, as determined by the Administrator, of such projects and programs, and that such grants may not be made after the seventh calendar year after the effective calendar year.

Subchapter III would authorize the Administrator of Veterans Affairs to carry out a program of grants, on a matching basis, to provide assistance in the establishment of cooperative arrangements among universities, colleges, junior colleges, community colleges, schools of allied health professions, State and local systems of education, hospitals and other nonprofit health service institutions, affiliated with the Veterans Administration, to coordinate and expand the training of professional and technical allied health services personnel; to develop and evaluate new health careers, and to improve allied health manpower utilization.

An application for a grant under this subchapter may be approved by the Administrator only upon his determination that—

1. The proposed projects and programs for which the grant is sought will make a significant contribution to improving education or training programs of the institution and that it will result in a substantial increase in the number of students trained at such institutions.

The provisions of this subchapter make mandatory fiscal control and accounting procedures as well as reports in such form as the Administrator may direct.

Mr. Chairman, it has been demonstrated that where physical and other facilities, necessary as a base for expansion of existing medical schools or for the inception of new schools, are already available and can be used for these purposes, new physicians can be produced faster and at lower cost than if new facilities must be built. Such demonstrations with the assistance of the Veterans' Administration have taken place at the University of California at Los Angeles, the New Jersey College of Medicine, and the Louisiana State University of Medicine at Shreveport.

The concept of the VA implementing role in formation of new medical schools is not new. Dr. Stafford L. Warden, Vice Chancellor of the Health Sciences Emeritus, UCLA, proposed in 1965 the establishment of new medical schools. To this end, he believed that a combination of a small city, a community hospital, a college, and a Veterans' Administration hospital, would be most desirable. He listed 31 locations as appropriate, including 15 where there are non-affiliated Veterans' Administration hospitals.

Similarly, Dr. George W. Thorn, in his recent presidential address to the Association of American Physicians, identified 63 moderate-sized cities where small medical schools could be advantageously located to the benefit of the local area and the nation.

The future potential of the Veterans' Administration in increasing the number of physicians appears to be in those hospitals which now have little or no affiliation with medical schools. Where VA hospitals have unused land, buildings, and/or staff, there exists the potential for starting new medical schools, with the hospitals serving as both primary clinical teaching resources and as suppliers of some of the faculty.

What is primarily evident in the background material associated with S.J. Res. 128 is that there is no end of possibilities for improving quality of patient care and increasing physician manpower. Since the Veterans' Administration hospitals have already demonstrated their capacity for assisting new medical schools get started, The American Legion supports the enactment of the measure as set forth in S.J. Res. 128.

In his statement before this Subcommittee, the VA Chief Medical Director, Dr. Musser, opposed those measures before you that would utilize VA funds for the purpose of S.J. Res. 128—that they would duplicate programs established under the Health Professions Education Assistance provisions of the Public Health Service Act—and that enactment of their approach would fragment authority for federal grants.

The arguments, we believe, are specious. Coordination of the application of these grants with the Secretary of Health, Education, and Welfare would avoid duplication and fragmentation of total federal effort in this area of education and training of health manpower.

His arguments are out of context with his support of the provisions in another bill which would authorize the Administrator to furnish training and education to health service personnel beyond the direct needs of the Veterans' Administration medical and hospital care facilities and to expand the authority of the Veterans' Administration to share scarce medical resources.

S. 2219, to amend 38 USC to authorize the Administrator of Veterans' Affairs to provide certain assistance in the establishment of new public nonprofit medical, health professions, and allied health schools and the expansion and improvement of health manpower training programs in Veterans' Administration facilities and in existing educational institutions affiliated with the Veterans' Administration.

Section 3 of this bill restates the existing language of 38 USC 4104(b) with the added provision that beginning with fiscal year ending June 30, 1972 and for each fiscal year thereafter, there shall be included in the budget required to be submitted to the Congress by Section 201 of the Budget and Accounting Act of 1921 a separate line item showing the estimated expenditures by the Veterans' Administration for the education and training of health manpower during such fiscal year.

We see no objection to the purpose of this amendment. It would give the Congress and others interested a measure of monies spent by the Veterans' Administration for this purpose, and it would give some protection against the diversion of funds from patient care.

With respect to the purpose of Section 4, we object to the amendment of 38 USC 5001(c) which would restrict new hopsital construction to close proximity to a school of medicine and osteopathy. While these affiliations have proven beneficial from the standpoint of medical care, research and education, there may develop needs for replacement or new construction not in close proximity to such schools.

We believe the existing language is adequate—that the location and type of facility shall be within the discretion of the Administrator and subject to the approval of the President.

Much of the language of the remainder of the bill parallels the purpose of S.J. Res. 128 and H.J. Res. 748. Their purpose, if effected as outlined, and the continued interest of the Administrator in the education and training of health manpower will meet the objectives of these provisions.

S. 2354, the Veterans Health Reform Act of 1971

As the title indicates, this is a complex measure to amend title 38, United States Code, to provide improved and expanded medical and nursing home care to veterans; to provide hospital and medical care to certain dependents and survivors of veterans; to provide for improved structural safety of Veterans Administration facilities; to improve recruitment and retention of career personnel in the Department of Medicine and Surgery; to provide for direct admission to VA nursing bed units; to provide hospital care for peacetime veterans for nonservice-connected conditions; to provide outpatient treatment of veterans for nonservice-connected disease or disability; and several other purposes.

Sections 101 (a) and (b) of the Act would provide that the Administrator may furnish hospital care to—

1. The wife or child of a person who has a total disability, permanent in nature, resulting from a service-connected disability; and
2. Widows and children entitled to death compensation or dependency and indemnity compensation.

Mr. Chairman, The American Legion is opposed to the concept that these dependents and survivors be given medical services and hospital care in Veterans Administration facilities.

Our current mandates provide that the organization sponsor and support legislation to amend title 10, United States Code, so as to authorize care and treatment of these survivors and dependents under provisions similar to those available to the dependents of those members of the Armed Forces retired for longevity or disability, and to the survivors of those deceased members who were on the disability or longevity retirement rolls.

Until such time as funding and facilities of the Veterans Administration are sufficient to care for eligible veterans, both service-connected and nonservice-connected, The American Legion feels that VA facilities should be utilized for medical and hospital care of veterans only.

As proposed by The American Legion, the amendments to title 10, USC, as amended by Public Law 89–614, would assure that these wives, widows, and children would be treated in community facilities near their place of residence, avoiding as much as possible the disruption of the family unit.

Section 102 would amend Clause (1)(B) of Section 610 of 38 USC to read: "Any veteran for a nonservice connected disability if he is unable to defray the expenses of necessary hospital care."

This language would permit treatment of peacetime veterans in VA hospitals for disability of nonservice origin. Traditionally, The American Legion has opposed the extension of eligibility for this benefit to those veterans not of war service.

Unlike peacetime veterans, those of war service do not have the option of time and place of duty. Legislation within the past several years has all but destroyed the distinction between those who served in time of war and those of peacetime service.

We strongly urge deletion of this amendment.

Section 102 would also insert language in Section 610 which would authorize direct admission to VA facilities for nursing home care.

The 1971 National Convention adopted the following resolution regarding this provision:

Whereas, 38 USC 620 provides that the Administrator of Veterans Affairs may transfer any veteran who has been furnished care by the Administrator in a hospital under his direct and exclusive jurisdiction to any public or private institution which furnishes nursing home care or care at the expense of the United States; and

Whereas, this restriction on direct admission to community nursing home care denies nursing home care to many severely disabled veterans; and

Whereas, legislation is under consideration in the 92nd Congress to amend 38 USC 620 to authorize direct admission to any public or private institution at United States expense; now, therefore, be it

Resolved, By The American Legion in National Convention assembled in Houston, Texas, August 31, September 1, 2, 1971, that The American Legion support enactment of legislation to amend 38 USC 620 so as to provide that the Administrator of Veterans Affairs may authorize direct admission to any public or private institution which furnishes nursing home care, or care at the expense of the United States.

We also support the other provisions of your bill that would increase the total nursing care beds in VA facilities.

In this context, Mr. Chairman, we urge the amendment of Section 620 of this title to authorize outplacement of veterans for nonservice-connected conditions into a contract community nursing home at VA expense for a period of nine months instead of the present six.

Section 103 would amend Section 612 of this title to provide that the Adminisrator may furnish medical services to any veteran for a nonservice-connected condition which is determined to be in need of prompt medical attention under regulations which the Administrator shall prescribe.

As worded, the proposed amendment would provide outpatient medical services for nonservice-connected conditions for peacetime as well as wartime service.

Earlier in this statement we had voiced opposition to further extensions of wartime benefits to peacetime veterans. In view of this position, we urge that the proposed amendment in Section 612(a)(4) be redrafted to read:

"(4) Any war veteran for a nonservice connected disability which is determined to be in need of prompt medical attention under regulations which the Administrator shall prescribe."

This section would also amend Section 612 to authorize the Administrator of Veterans Affairs to furnish medical services to the wife or child of a veteran who has a total disability, permanent in nature, resulting from a service-connected disability, and to the widow and children entitled to death compensation or dependency and indemnity compensation from the Veterans Administration.

Our rationale for opposing this provision is given above under the discussion of the amendment proposed in section 101 of your measure.

Title II of this bill seeks improvements in the administration and personnel processes of the Department of Medicine and Surgery. Among its several provisions are those that would pay increased compensation for those nurses and licensed vocational nurses for overtime, night duty, duty on Saturdays, Sundays and legal holidays.

We believe these provisions will place the VA Department of Medicine and Surgery in a more competitive position in recruitment and retention of nurses and licensed vocational nurses. The Veterans Administration's position would be improved by the authorization of additional compensation for those nurses on stand-by duty for emergency purposes—a common practice in community hospitals.

A provision of this title would also establish parity in federal service of doctors and dentists in the Armed Forces in computation of retirement for those with 20 or more years of service.

Presently, physicians and dentists on active duty in the Armed Forces for 20 or more years may credit, for computation of retired pay, up to five years of time devoted to the pursuit of a degree in medicine, osteopathy, or in dental surgery or medicine, including the time spent in full-time internship.

S. 2355 would amend 38 USC so as to afford advanced residency type training to medical personnel of the Veterans Administration and other federal departments and agencies at Regional Medical Centers established at VA hospitals throughout the United States.

Although this concept has not been discussed by our policy-making bodies, we see no reason for opposing its enactment. There is an apparent need for continuing or postgraduate medical education.

Establishment of these Medical Education Centers would enhance the education and training of VA and other federal health manpower. It would be particularly beneficial to those medical and health care staff in nonaffiliated VA hospitals.

Several of the bills before you have not been referred to or discussed in this statement. Some, as you know, duplicate the provisions of S.J. Res. 128 and H.J. Res. 748. Others have been either partially or totally covered under our remarks on S. 2354.

Thank you for receiving the views of The American Legion.

We ask that there be included in the record copies of our Resolution 578 approved by the 1970 National Convention; Resolution 40 approved by the Fall 1970 National Executive Committee meeting; Resolutions 9 and 18 approved by the Spring 1971 National Executive Committee meeting, and Resolution 619 approved by the 1970 National Convention.

RESOLUTION NO. 578

Whereas, 38 USC 620 provides that nursing home care may not be furnished at the expense of the United States for more than six months in the aggregate in connection with any one transfer except where in the judgment of the Administrator a longer period is warranted in the case of any veteran; and

Whereas, a study by the Committee on Veterans Affairs, House of Representatives, of 8863 VA patients outplaced in a community nursing home demonstrated that 1927 required care beyond six months, and 538 may require an extension; and

Whereas, many bills have been introduced in the Congress to amend 38 USC 620 so as to extend nursing home care at the expense of the United States to nine months; now, therefore, be it

Resolved, By The American Legion in National Convention assembled in Portland, Oregon, September 1, 2, 3, 1970, that The American Legion support the enactment of legislation to amend 38 USC 620 so as to extend community nursing home care at VA expense to nine months.

RESOLUTION NO. 40

Whereas, chapter 55 of title 10, United States Code, authorizes care of the dependents of those members of the Armed Forces who die on active duty in military medical facilities; and

Whereas, the Military Medical Benefits Act of 1966 (Public Law 89–614) amended chapter 55 of title 10 to provide both hospital and outpatient care in civilian facilities for dependents of active duty members, retired members entitled to retired, retainer or equivalent pay (including retired reservists and their dependents) and survivors of deceased active duty and eligible retired members; and

Whereas, no provision exists for the care and treatment in military or civilian medical facilities of the dependent survivors of those veterans who died of a service-connected disability after discharge from active duty in the Armed Forces; and

Whereas, The American Legion is cognizant of the economic hardships endured by permanently and totally service-connected disabled veterans in their efforts to provide adequate medical care for their dependent wife and children; and

Whereas, The American Legion believes that the Federal Government has an obligation to assist permanently and totally service-connected disabled veterans to adequately provide for the health needs of their dependents; and

Whereas, The American Legion is opposed to the hospitalization of nonveterans in Veterans Administration hospitals; now, therefore, be it

Resolved, By the National Executive Committee of The American Legion in regular meeting assembled in Indianapolis, Indiana, October 21–22, 1970, that The American Legion shall sponsor and support legislation to provide that the surviving dependents of those war veterans who die of a service-connected disability after discharge from active duty in the Armed Forces, as well as the wives and children of permanently and totally service-connected disabled veterans, shall be authorized hospital and outpatient care in civilian medical facilities at Government expense.

RESOLUTION No. 9

Whereas, the Administrator of Veterans Affairs may furnish such medical services as he finds to be reasonably necessary to any veteran for a service-connected disability; and

Whereas, the Administrator may furnish such medical services as he feels reasonably necessary to any veteran in receipt of increased pension or additional compensation or allowance based on the need of regular aid or attendance or by reason of being permanently housebound; and

Whereas, the Administrator may also furnish medical services for a nonservice-connected disability under the following circumstances;

(1) Where such care is reasonably necessary in preparation for admission of a veteran who has been determined to need hospital care and who has been scheduled for admission;

(2) Where a veteran has been granted hospital care, and outpatient care is reasonably necessary to complete treatment incident to such hospital care; and

Whereas, these restrictions on outpatient medical services prohibit the Administrator from providing such services to many veterans who do need them but who do not require hospital care; and

Whereas, it is believed by The American Legion that the Administrator, within the limits of VA facilities, should have the authority to furnish such medical services to any war veteran for any nonservice-connected disability; now, therefore, be it

Resolved, By the National Executive Committee of The American Legion in regular meeting assembled in Indianapolis, Indiana, May 5 and 6, 1971, that The American Legion sponsor and support legislation to amend 38 USC, chapter 17 so as to provide that the Administrator of Veterans Affairs, within the limits of Veterans Administration facilities, may furnish such medical services as he finds reasonably necessary to any war veteran for a nonservice-connected disability.

RESOLUTION No. 18

Whereas, the maintenance and operation of a medical care program by the Veterans Administration, second to none available in the nation, is and has always been a matter of prime concern to The American Legion; and

Whereas, to help achieve the above-stated goal The American Legion has encouraged and supported the affiliation of Veterans Administration medical facilities with accredited medical schools throughout the nation; and

Whereas, the nation currently is experiencing a critical shortage of personnel in nearly all professional and para-professional categories in the field of health services; and

Whereas, it would strengthen and enhance the medical care program of the Veterans Administration were that agency to undertake a special program designed and funded to expand medical schools now in being and to establish new medical schools at appropriate places in the nation; and

Whereas, there is presently pending in the Congress legislation that, if enacted into law, would achieve the goals stated in the clause next above; now, therefore, be it

Resolved, by the National Executive Committee of The American Legion in regular meeting assembled in Indianapolis, Indiana, May 5 and 6, 1971, that The American Legion shall support legislation now pending in the Congress that will, if enacted into law

a. Authorize the Administrator of Veterans Affairs to make available by lease to state agencies, facilities under the control and jurisdiction of the Veterans Administration, to be used by the States for the establishment of new medical schools that will be fully accredited and affiliated with the Veterans Administration medical care program;

b. Authorize the grant of Federal monies by the Administrator, to be used by States to partially defray the cost of establishing new medical schools that will be fully accredited and affiliated with the Veterans Administration medical care program;

c. Authorize the grant, on a matching basis, of Federal monies to medical schools that have maintained affiliation with the Veterans Administration, to assist such schools to improve and enlarge their facilities.

RESOLUTION No. 619

Whereas, 38 USC 620 provides that the Administrator of Veterans Affairs may transfer any veteran who has been furnished care by the Administrator in a hospital under his direct and exclusive jurisdiction to any public or private institution which furnishes nursing home care or care at the expense of the United States; and

Whereas, this restriction on direct admission to community nursing home care denies nursing home care to many severely disabled veterans; and

Whereas, legislation is under consideration in the 92nd Congress to amend 38 U.S.C. 620 to authorize direct admission to any public or private institution at United States expense; now, therefore, be it

Resolved, By The American Legion in National Convention assembled in Houston, Texas, August 31, September 1, 2, 1971, that The American Legion support enactment of legislation to amend 38 USC 620 so as to provide that the Administrator of Veterans Affairs may authorize direct admission to any public or private institution which furnishes nursing home care, or care at the expense of the United States.

STATEMENT OF V. EUGENE McCRARY, M.D., CHAIRMAN OF FEDERAL LEGISLATION COMMITTEE, AMERICAN OPTOMETRIC ASSOCIATION

Mr. Chairman and members of the committee: I am Doctor V. Eugene McCrary, Chairman of the American Optometric Association's Committee on Federal Legislation and an optometrist actively engaged in private practice in College Park, Maryland. The American Optometric Association is an organization composed of 16,449 members located in fifty States and the District of Columbia.

We support the general purposes of S. 1924 and S. 2354 which you have before you for consideration. When this legislation is enacted, it will represent a major step forward in providing improved health care to veterans and their dependents. This would be achieved chiefly through improvements the legislation would permit in terms of recruitment and retention of career health personnel in the Veterans Administration Department of Medicine and Surgery.

Present law and administrative procedures in the Department of Medicine and Surgery make only minimal provision for adequate optometric vision care under VA programs for those who have served our Nation in the uniformed service. To completely fulfill the intended role of the Department of Medicine and Surgery, complete and comprehensive health services—including vision care—must be provided to our veterans and certain of their dependents or survivors.

The need for professional vision care is universal, and has been long recognized by the Congress and the health community generally as a primary health care service whose absence can and all too frequently does lead to a need for much more expensive and painful catastrophic care.

Complete vision care requires that an individual have a professional eye examination at least once every two years. While an American citizen is a member of the uniformed services, his vision care needs are quite adequately met, through the combined professional skills of optometrists and ophthalmologists. Each individual military dependent has the further assurance that in the event eye care personnel at his base carry a work load so heavy as to require an unduly long waiting period, the same services may be obtained in the private sector upon approval by the base commander under the CHAMPUS program, exclusive of materials.

The incidence of vision anomalies among veterans is little different from the general population, where 43% of all individuals require some type of visual correction (according to the National Center of Health Statistics in GPO publication "Vital and Health Statistics, Series 10, Number 53").

The 533 optometrists providing basic vision care for 1,454,000 Army personnel, 1,020,872 members of the Navy and Marine Corps, and 904,190 Air Force personnel work in close cooperation with the ophthalmologists in military vision care facilities. Optometrists perform the basic visual examinations, prescribe the correction needed and, as in civilian practice, refer the patient to an ophthalmologist if there are signs of ocular pathology or systemic disease. This is fully consistent with the education today's optometrist receives in his two years of pre-optometry and four years of professional schooling leading to the O.D. (Doctor of Optometry) degree awarded in all eleven of the Nation's schools and colleges of optometry.

The need for optometric services in the civilian population has also been recognized repeatedly by the Congress. In addition to Federal grants for construction, institutional support, special projects grants, student loans and scholarships for schools and colleges of optometry under the Health Professions Educational Assistance Act, the Congress also specifies optometrists for various purposes under Titles V, VII, X, XV, XVI, XVIII, and XIX of the Social Security Act; in the Vocational Rehabilitation Act of 1968; in the Model Cities and Comprehensive Health Planning Acts; under Title XI of the Federal Housing Act for purposes of FHA-insured group practice facilities loans; and a multitude of other public laws relating to health care.

Administratively, optometrists serve as consultants to the HEW Assistant Secretary for Health and Scientific Affairs, and to various Federal programs including the aerospace program, Project Head Start, the Department of Transportation, the Office of Emergency Preparedness, and others.

Optometrists are actively involved in Federal-state programs dealing with Comprehensive Health Planning, and many provide visual care through Neighborhood Health Centers such as that located in the Watts area of Los Angeles, California. Some vision care programs in Neighborhood Health Centers are limited to basic vision screening programs; others provide complete optometric examinations and appropriate referral or formulation of a prescription; others include both these types of services mentioned and, in addition, supply the necessary corrective lenses or visual training courses. Beneficiaries of Neighborhood Health Centers are most often those whose incomes are at or below the established poverty level, and to date are providing services primarily in the inner city and ghetto areas of major metropolitan centers.

The indigent and medically indigent of all ages are the primary beneficiaries of Medicaid, the Federal-State program authorized by Title XIX of the Social Security Act. Optometric services have been included under Medicaid programs in no less than thirty-seven jurisdictions. Thirty-six jurisdictions also provide the necessary eyeglasses. Of the thirty-seven Medicaid programs which include optometric services, 25 provide such care for the medically indigent, while the other 12 do so only for individuals who qualify for Federally supported (welfare) financial assistance.

All these indicators of acceptance by the Federal government of the need for professional vision care as an element in comprehensive health care programs suggest strongly that the lack of emphasis on vision care for those who have completed their active military service results in an inequity for our veterans.

The American Optometric Association fails to see the rationale of providing professional vision care to a man while he is on active duty and denying him the same quality of care upon completion of his tour of duty. We believe that each and every one of the 800,000 veterans being discharged annually should be provided some form of professional eye care within a reasonable time after his discharge. Perhaps a sound approach would be for the VA to provide the professional services on a staff-based or a contractual basis and require the veteran to obtain the corrective lenses necessary, at his own expense.

To establish and coordinate an expanded vision care program within the Veterans Administration health facilities and to properly direct the present eye care program would require the creation of the position of Optometry Chief in the Department of Medicine and Surgery and a minimum of one optometrist as a full time staff member in each VA clinic or hospital to care primarily for the inpatient population.

In order to establish and maintain the present program and a program for expanded vision care for VA health beneficiaries, the low Veterans Administration pay scales for optometrists in VA facilities must be made comparable, by statute, to the grade and pay scales granted dentists and physicians.

With the introduction of expanded optometric vision care services for veterans, it becomes evident that an efficient system of supervision and coordination is needed within the structure of the Veterans Administration. This could be accomplished by authorizing a new position of Chief Optometry Officer within the Department of Medicine and Surgery. A well qualified optometrist in such a position would provide the expertise necessary to assure that all optometrists in VA facilities supply top quality vision care equally to all veterans and their dependents who qualify for services. If the Congress cannot see its way clear to provide the expanded services we recommend, it remains equally important that a Chief of Optometry be designated, to assure better coordination of the limited services available now.

We believe that S. 1924 and S. 2354 should be amended to include an expanded vision care program, and must be made available to all veterans with partial or total disabilities, and to the families of such veterans regardless of the extent of the veterans' disabilities. Any such plan should make specific provision for visual training and developmental vision services for children of qualified veterans, as this is the type of service which is so often neglected because of its relatively long-term nature and the continuing cost of professional services.

The American Optometric Association believes that the need is urgent for establishment of an expanded optometric vision care program in the Veterans Administration Department of Medicine and Surgery. To achieve this, we urge adoption of the following amendments to S. 1924 and S. 2354 as they appear in the attachment to this statement.

S. 2219

Mr. Chairman, President Nixon's health message to the Congress in February of this year requested that methods be developed whereby the Veterans Administration health care facilities could be used to supplement local medical resources and assist in health manpower education.

The American Optometric Association believes that S. 2219 would help implement this goal.

We support the concept of utilizing all facilities to expand health care in America and at the same time provide better care for our veterans and we are pleased to support the comprehensive approach to meeting this problem as expressed in the terms of S. 2219, utilizing all those professions' participation under the Health Professions Educational Assistance Act. This would more nearly produce a consolidated, comprehensive health team approach, which the Congress has wisely attempted to establish in most of the new health programs enacted in the past decade.

The Veterans Administration's goal of providing health care to its patients will be better served and at the same time the training of health professionals to meet the comprehensive health care needs of America will be expanded.

SUMMARY

In summation, the American Optometric Association urges adoption of amendments which would provide for the following needed improvements in the visual care program of the Veterans Administration:

1. A full professional eye examination for each veteran, within a reasonable time after his discharge, for each veteran discharged from the military service, with such examinations to be provided by staff optometrists or on a contractual arrangement with the Veterans Administration;
2. An expanded vision care program for disabled and partially disabled veterans, regardless of the extent of their disabilities, and for dependents of such disabled veterans, including specifically vision training and developmental vision services for children of disabled veterans;

3. A minimum of one optometrist on the staff of each VA hospital and clinic, to provide primary vision care services to the inpatient hospital population and to out-patients in the clinical setting;

4. Authorization of a new position, Chief of Optometry, within the VA Department of Medicine and Surgery, whose responsibility it would be to coordinate the expanded vision care program for veterans and their dependents;

5. Increases in Veterans Administration pay scales for optometrists in VA facilities, to assure that enough optometric manpower will be available to serve the needs of veterans and their dependents; and

6. The adoption of S. 2219, authorizing assistance by the VA Department of Medicine and Surgery to all schools educating professionals for the primary health care professions.

We believe that the eye care needs of veterans and their dependents would be more adequately met by adoption of the amendments we have outlined today, and as stated, the technical language to accomplish these ends are attached. The profession of optometry stands ready to aid the Congress and the Veterans Administration in whatever manner possible to implement such a program.

I would like to thank you for your time and attention.

RECOMMENDED LANGUAGE

A. That a new Section 103 of S. 1924 and a new Section 106 of S. 2354 be added to read as follows:

> "Section 601 of Title 38, United States Code is amended by inserting after the word 'optometrists services' and before the word 'dental services' the words '(and vision services as provided in Section 612[c]).' "
>
> "Section 612 of Title 38, United States Code is amended by inserting after the words 'is suffering' in Subsection (b)(5) the following new Section '(c) an outpatient eye examination shall be furnished to all persons who apply for the same within 6 months of discharge, not to include, however, the costs of lenses or other appliances.' "

B. That a new Section 262(c) be added under S. 1924 and a new Section 202(8) be added under S. 2354 to read as follows:

> "That Section 4103(a) of Title 38, United States Code is amended by adding a new number (8) to read 'a Chief Optometrist appointed by the Administrator.' "

C. That after the words "Director of Dietetic Service. . . ." in Section 203(a) of S. 1924 and the words "Director of Dietetic Services. . . ." in Section 206(a) in S. 2354 the following be added:

> "Chief Optometrist, $26,547 minimum to $33,627 maximum, and Section 4107(a) of Title 38, United States Code is amended by redesignating those provisions stating 'physician and dentist' to read 'physician, dentist and optometrist schedule.' "

STATEMENT OF GEORGE JAMES, M.D., PRESIDENT, MOUNT SINAI MEDICAL CENTER AND DEAN, MOUNT SINAI SCHOOL OF MEDICINE, NEW YORK CITY

Mr. Chairman and members of the subcommittee, I am pleased to respond to your invitation to give my views on S. 2219.

I would like to give you some of my background, so the subcommittee can be aware of the experience I have had with the Veterans Administration, and in the public health field. Before becoming a medical school dean in 1965. I had worked for more than 20 years in general public health work. I worked for the States of Tennessee, Maryland, Ohio, and New York. My last public health assignment was Commissioner of Health for the City of New York. I suggest that this background has permitted me to understand the possibilities, as well as the difficulties, of working out suitable relationships between health agencies and institutions. I have some knowledge of the VA system as well. I am a member of the exchange of medical information committee which is a subcommittee of the special medical advisory group, and I have made numerous on-site visits to VA hospitals and have been involved in the review of projects submitted by them. The Bronx VA hospital is affiliated with Mount Sinai, as are four other hospitals.

Gentlemen, it is no news to anyone in this room that we have a crisis in health care in the Nation. Not only are the costs going up, but even more significant is the enormously sharp increase in demand and the increasing inadequacies in the distribution of medical services. Last year there was one urban area in New

York City in which there were 50,000 ghetto dwellers with five physicians to take care of them. Thirty years ago there was half that population in the area, and ten times the number of doctors. It may well be worse this year.

I recognize that there are other problems besides the manpower problems, including improvement of VA hospital facilities, the improvement, updating, and staffing of our central city hospitals, and many, many others—but because there are so many other problems does not mean that we should move away from consideration of the manpower problem.

The system of VA facilities and manpower is the greatest health care system that has ever been developed in the history of man. It is a tremendous resource, and it is an extremely scarce resource. Regardless of the problems that we face in the utilization of this system, I think we must always look positively upon its use—in this time of manpower crisis there is simply no reason for us to turn away from a major resource which would help to meet that crisis.

The concern in regard to this legislation, expressed by many individuals and organizations, about the financial distress of the Nation's medical schools is valid—many of my fellow deans and I worry continually about financial stability. Federal government legislation has made many demands for expansion, but consistently the government has appropriated far less funds than those which were authorized, and far less than those required to meet the government's demands.

It is also true that some VA installations are aging and increasingly obsolescent physical facilities. Further, I agree with the view that the new schools should be located for maximum benefit to the health care of the Nation. I am also concerned about the fragmentation of federal support for medical education and for a balanced approach to assure broad training capabilities. I am quite certain, however, that this Committee and those others concerned with funding improvements in facilities, are well aware of the systems' shortcomings, and are doing their best to cure them. We who work closely with the VA will continue to help you push for those improvements.

I know that the Medical Director of the VA, himself a former medical school dean, will work very hard to assure that new schools established under this legislation are properly located. And further, I see that the Medical Director is working very hard to open as many relationships as possible with other federal agencies, especially with the Department of HEW. I am informed by a staff member of mine who has worked with personnel of HEW that there would be, from their point of view, no serious difficulties in working out the problems that might come about as a result of this bill. Indeed, it would represent an opportunity to develop a bridge of relationships which have not heretofore existed. In my view, so often real cooperation does not take place until a specific legislative or administrative act or policy is set down—this is what S. 2219 can do.

Like the Association of American Medical Colleges, I am concerned with the quality of medical education. Now the Liaison Committee of Medical Education of the AMA and the AAMC is charged with the accreditation of medical schools in the United States. I am confident hat this body will continue to review the qualificaions of all medical schools for accreditation. It seems to me that this should be totally acceptable to the Veterans Administration, as they understand the process, and indeed have already worked for a long period of time with 81 medical schools which are already subject to this process.

The concern that there is uncertainty about the continued funding of schools created under this Act is also valid. It seems to me that the funding process drops off too sharply—perhaps the initial 90% assistance should be continued for a year or so longer before dropping off. Additionally, any bill report and other legislative language in support of this Bill, should include the strongest requirements that the Medical Director and Administrator be as exacting as possible in the selection of areas, and make as certain as possible the willingness of the state and local governmental bodies concerned with the new schools, to continue support.

One thing is certain: what we do not need in this country are more schools failing because of inadequate support. If that would happen, we would only be compounding our problems. I have sufficient faith in the Administration of the VA to believe that these Congressional concerns will be heeded.

The concern that the Department of HEW and the VA not become entangled in a web of potentially conflicting and possibly contradictory regulations and objectives is also important. I know that the construction program Congress passed a number of years ago, and extended in the Health Manpower Act of 1968, required, for example, the submission of different application proposals for funds from allied health, nursing, and medical school construction programs, with different advisory committees for each. This added months to the development of medical education centers. The problem is being solved, I understand, in the currently pending legislation before the Congress. There also was a case where different proposals had to be developed for education, research and library facilities, each proposal being reviewed by different committees. In one case, this resulted in the approval of the first and third floors of a medical school, but the disapproval by another committee of the second and fourth floors—of course by negotiation this was finally worked out, and the 1968 bill corrected that problem. Now, those examples took place inside one bureau of the Department of Health, Education, and Welfare.

I am sure that sufficiently strong language in the bill and supporting documents would go a long way to preventing such potentially conflicting and contradictory departmental regulations.

But with all the difficulties that such relationships present, we might consider that they are also opportunities. For so long have the various health agencies of the federal government been fragmented, that now many of them still have only the most formal and distant relationships.

I compliment the Committee on their proposed support of those schools already affiliated with the VA hospitals, to improve and enlarge their facilities. One major need we have now is the enlargement of the schools to produce more students. Therefore, I am happy to see included in S. 2219 provision for financial assistance, on a non-matching basis, to affiliated schools.

Mr. Chairman, I commend you for producing this Bill, and for showing the willingness you have to push forward in the area of educating more health professionals. This is an imperfect bill, but nearly everything in the world is. It can and will be improved upon by this Committee. I deeply appreciate your request that I comment upon it, and for asking my colleagues, particularly as represented by the AAMC.

As the President of a major medical center, and the Dean of a new medical school, I appreciate your interest in these problems, and your dedication to solving them. I see very favorable signs that the Congress is growing increasingly knowledgeable about the crisis in health manpower, and the willingness it is increasingly showing to authorize and appropriate the funds needed, and to utilize various federal programs in a better way.

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

Mr. Chairman and members of the subcommittee: Several of the legislative proposals before the Committee deal with the general subject of health manpower training and education. These include S. 2219, the "Veterans' Administration Health Manpower Training Act of 1971," S. 2355, the "Veterans' Administration Continuing Medical Education Act," and H.J. Res. 748, the "Veterans' Administration Medical School Assistance and Health Service Personnel Education and Training Act of 1971." Other bills, including S. 1924, the "Veterans' Medical Care Act of 1971, "S. 2354, the "Veterans' Health Care Reform Act of 1971," as well as S. 2219, provide for expanded veterans' benefits.

We shall first discuss the bills relating to manpower training and education. Before presenting our comments on these legislative proposals, we wish to acknowledge the many fine contributions which the VA system has made to medical education and production of health manpower. The relationship between VA hospitals and American medical schools has been particularly beneficial to both parties, permitting medical schools to expand their clinical teaching facilities and improving the quality of health care provided in the hospitals. Thousands of medical students and graduates have received significant portions of their education and training in VA hospitals over the past 25 years. It is very important that this relationship continue to be supported and expanded during the present, unprecedented period of expansion of medical school enrollment.

Similarly, we believe that it is wise to use the VA system for the training of other health professionals, including dentists, nurses and allied health personnel who provide assistance to physicians. The VA system has been an active "consumer" of these health professionals, and it seems appropriate that the system contribute to their production.

In this regard, the American Medical Association is in support of those provisions of S. 2219 and H.J. Res. 748 which would expand and improve health manpower training programs and develop new educational and training programs for health personnel needs in existing VA facilities and in educational institutions affiliated with the Veterans' Administration. These provisions would permit an increase in the number of medical and allied health personnel which can be trained in existing VA hospitals and affiliated institutions and would support efforts to develop new and improved methods of training and new types of allied health personnel. We note with approval that provisions have been included in S. 2219 to require that such educational programs meet the standards of the official professional accrediting bodies.

The American Medical Association is also in support of S. 2355, under which there would be provided continuing medical and related education programs for medical and health personnel of the VA. Nothing is more important to the maintenance of professional competence than regular participation in continuing education, and the AMA strongly encourages all physicians to engage regularly in such activities. Additional support is needed in this field and particularly for residency- type, refresher and special training experiences, or "clinical traineeships," such as are proposed in this legislation. The AMA wishes to propose that a provision be added to this legislation that the continuing education programs established be required to meet AMA accreditation standards in this field. AMA established in 1964 a voluntary system for the formal accreditation of institutions offering continuing education programs. As of this date, 99 institutions have qualified for such accreditation. In addition, it should be made clear that VA physicians and other health personnel could continue to avail themselves of continuing education programs outside the VA establishment, since continuing professional contact with their peers in private practice can be of distinct advantage to both private and VA personnel.

Many of the provisions of these various legislative proposals, as indicated above, are meritorious and AMA is in agreement with them. There are, however, some provisions which are a matter for concern and which we cannot support. These are the provisions in S. 2219 and H.J. Res. 748 whereby the VA would be authorized to make grants to public colleges and universities to assist in the establishment of new medical schools, allied health schools or area health education centers.

AMA is in complete agreement with the need to establish more new medical schools and to increase the national enrollment of medical students and the production of physicians, and we have testified to this effect repeatedly before various Senate and House committees. As a result of continuing efforts by the profession and the academic community, with support from the Health Professions Educational Asssitance Acts, 17 new medical schools were established during the decade of the 1960's. Five more medical schools will open their doors in 1971 and five additional schools in 1972. Three other schools are officially classed as "in development," and several others are likely within the next few years. The number of new schools formally in development (13) already exceeds the number called for by the Carnegie Commission report (9) and the number proposed in the Association of American Medical Colleges bicentennial proposal (12). The AMA does not advocate limitation in the number of new schools nor the selection of their location by some national agency.

However, in spite of its strong advocacy of more new medical schools, the Association must oppose the provisions in proposed legislation creating authority in the VA to assist in establishing new state medical schools through grant for facilities and payment of faculty salaries. We urge your full consideration of the following:

(1) The proposal duplicates support provided for the establishment of new schools by the Health Professions Educational Assistance Act. While it is specified that there should be coordination between the Veterans' Administrator and the Secretary of HEW, we are still concerned about dividing responsibility for the support of medical education between two federal agencies and would prefer to see this authority in HEW. We urge that authority for assisting medical schools not be divided, but should remain in HEW.

(2) The proposed legislation would encourage the selection of the location of a new medical school on the basis of the location of an existing VA hospital which could be in a relatively remote area, rather than upon more traditional, and we believe more appropriate and reliable, bases. In all probability, it would be difficult to recruit faculty and provide the continuing support for the operation of the school if an inappropriate location were chosen because of the temporary VA support.

(3) Medicals schools should ideally be established in a university, to provide the proper base for academic growth, investigation and scholarly pursuits of a

medical faculty. It is unlikely that the use of a VA facility or an adjacent location will permit this close relationship to a university.

Certainly the use of VA facilities in conjunction with new medical schools should continue to be encouraged. However, there is nothing in the present health manpower legislation which precludes such arrangements. New state medical schools built where warranted in conjunction with VA facilities, can be amply supported under current health manpower legislation, and accordingly, we do not see the need nor the advisability of this proposed program. We believe that the Veterans' Administration and its facilities can serve a significant role in achieving the nation's goals for development of health manpower However, medical education should not become a primary mission of the VA.

The American Medical Association is dedicated to maintaining high standards of medical education, while increasing the number of medical schools and the production of physicians. We believe that this can best be done through the existing and proposed Health Professions Educational Assistance Acts.

We will now direct our attention to the bills expanding veterans' benefits.

S. 1924 would, among other things, permit the furnishing of medical outpatient services to veterans for non-service-connected disabilities where such care is reasonably necessary in preparation for hospital admission, or where such care is reasonably necessary for a veteran who is determined to need hospital care if he is not treated. Under current provisions, hospitalization is provided for veterans for non-service-connected disabilities, on a space available basis, where the veteran is not able to afford such care otherwise. The role of the Veterans' Administration primarily is to see that veterans with service-connected disabilities are given appropriate care. However, where the veteran is to be given treatment in the hospital for non-service-connected disabilities, it would seem appropriate that preliminary outpatient services be used where medically appropriate, in order to reduce total costs. To provide, generally, however, for outpatient care for one who is "determined to need hospital care if not treated" would seem to enlarge the responsibility of the VA for general outpatient care. The language is broad and susceptible of wide interpretations, possibly resulting in a greatly increased burden on VA outpatient facilities. While the Association supports the use of the least costly service appropriate for the medical indication, we believe that the language authorizing care where it is reasonably necessary in preparation for hospital admission should include safeguards to assure appropriate use of the outpatient services of the VA facility.

S. 1924 also provides for reorientation of the mission of the Veterans' Administration with respect to medical education. We have indicated above that while the VA should have an effective role in our system of medical education—as it most certainly does now—medical education should not become a primary mission.

S. 1924 also authorizes the VA to contract for scarce medical specialty services from other agencies or institutions, or to contract for the use of unused VA hospital beds, with supporting services, with other hospitals, medical schools or clinics in the medical community. Scarce medical specialty services should be available for VA patients. As to the other provision, however, many questions—fiscal, medical, administrative—arise concerning its practical implementation. Safeguards should be provided, for instance, concerning a continuation of the medical staff supervision which the patient would ordinarily have as a patient in the community facility. In any event, the provision should not be so administered as to result in the creation of new VA facilities primarily for community use.

S. 2354 is an omnibus bill containing many amendments expanding the authority of the VA in providing health, domiciliary and medical care. The expansion would not only increase the role of the VA in furnishing services to veterans, but would include, as beneficiaries eligible for care, the dependents of the veteran.

S. 2354 would authorize the VA to provide medical care and treatment to dependents and dependent survivors of eligible veterans. The services could be on an inpatient, outpatient and domiciliary care basis.

Such an amendment would represent a radical departure from the present role of the Veterans' Administration. It would mean a shift in policy of major proportions. In his testimony before the Subcommittee, Doctor Musser, Chief Medical Director of the Veterans' Administration, described the approach of this bill as "adding potentially 40 million adults and children to the patient care liability of the VA hospital system." In so doing, he stated that it "threatens to so overload the capacity of VA's system as to render it unable to provide quality care for those beneficiaries for whom the system was originally established and who remain the prime obligation of the Government—the service-disabled veterans."

We can see no justification for the addition of the proposed beneficiaries, which would add an impossible burden on the VA system, and we strongly oppose this provision. Such coverage, blanketing in this huge block of the population, would in effect amount to a form of national health insurance. This issue is yet to receive full debate in the Congress, and we submit that a coverage for the dependents of servicemen would appropriately be under the Medicredit proposal of the American Medical Association, which relates the federal assistance to the financial need of the individual, providing full assistance for the poor, and which could provide family care in the community, rather than a possibly distant VA hospital.

In addition, the care would extend to any veteran for a non-service-connected disability (excluded first-aid or dispensary services for minor illnesses or injuries) which is determined to be in need of prompt medical attention. This also appears to be an undue extension of the primary function of the VA, and this also could add a strain on the ability of the VA to furnish quality care for those with service-connected disabilities.

Certain administrative provisions of S. 2354 appear to be beneficial. For instance, under the bill the Administrator may contract for the central administration of interns and residents, and provision is made for malpractice coverage. Also, the Administrator may enter into contracts to provide scarce medical specialist services at VA facilities with medical schools, clinics, and any other group or individual capable of furnishing such services.

On the other hand, we question such provisions as requirements for maintenance of a fixed number of nursing home beds, or the conversion of unused hospital beds into nursing home beds. The requirement of a fixed staff-patient ratio based on other hospitals in the community may not take into account the different composition of the patient load in VA and non-VA hospitals.

Certain provisions of S. 2354 are similar to provisions in S. 1924 discussed above. Our comments concerning the use of excess VA beds by community sources, for example, would apply to the similar provision in S. 2354.

In summary, the American Medical Association supports a continued role for the Veterans' Administration with respect to medical education and training of health manpower and we support a continuation and expansion of the present authority of the VA for the training for health personnel needs in the VA system. We do not support, however, the provisions which authorize the involvement of the VA in the creation of new state medical schools. Medical education should not become a primary mission of the Veterans' Administration. We endorse the provisions for the support of continuing education of VA health personnel and the creation of the VA centers for this purpose, but we also suggest that the VA personnel have access to continuing education opportunities in courses outside the federal VA system. With respect to the bills expanding care and treatment of veterans, we oppose most strongly the provisions expanding the VA care obligation to dependents of veterans. The outpatient services for veterans with non-service-connected disabilities should relate to the provision of services in preparation for the hospitalization of the veteran. We view as beneficial the provisions which will assure the veterans of the services of scarce specialty personnel in the community. We question the advisability of provisions permitting the use of excess VA beds for service to the community at large. We can also support the provisions for central administration for interns and residents programs. We question also those mandatory requirements as to the number of nursing home beds and conversion of unused hospital beds into nursing home beds, as well as the establishment of fixed staff-patient ratios.

Statement of American Dental Association and American Association of Dental Schools

The American Dental Association and the American Association of Dental Schools welcome this opportunity to present our views of the proposed legislation dealing with the medical programs of the Veterans' Administration. Our organizations are presenting a joint statement not only to conserve the time of the Committee but to indicate to you that we share an identical concern and commitment to the education and training of dentists and dental auxiliaries.

The Nation's critical shortage of medical and dental professionals and all types of allied health professionals is an accepted fact. The very serious problem with respect to the number and distribution of dentists in many areas of our country has received considerable attention during recent hearings on health manpower legislation before the House Committee on Interstate and Foreign Commerce and the Senate Committee on Labor and Public Welfare.

There are, at present, 53 dental schools, of which 51 are linked in an affiliating relationship with the Veterans' Adiministration's Department of Medicine and Surgery. At the beginning of the coming year approximately 17,000 students will be enrolled and approximately 3,806 students are expected to graduate next June. With the dental manpower shortage conservatively estimated to number 20,000 dentists, it is obvious that a way must be found, with Federal participation, to increase the number of dental schools and, wherever possible the output of present operational dental schools.

The financial situation of the dental schools system today is dangerously precarious. For 1969–70, as an example, 41 surveyed schools, after receipt of federal institutional grants, reported a composite deficit of nearly $50 million. Twenty-two schools had deficits in excess of one million dollars and the average U.S. dental school had an operating deficit of $1.25 million. The present hand-to-mouth existence of so many schools, an existence that stifles innovation and consumes so much of the energy that should be directed toward increased productivity and enhanced excellence, must be eliminated.

The October, 1970 report of the Carnegie Commission on Higher Education recommended a greater role for the Veterans' Administration hospital system in the overall national health system. Our organizations believe strongly that the health manpower problem in this country needs to be addressed by broad national legislation such as H.R. 8629 which is being considered by the Senate-House Conference Committee. However, our organizations also believe that this Subcommittee is considering legislation that would create a new source of assistance for the training of additional dentists and, at the same time, be of particular benefit to the Veterans' Administration and to certain areas of the country which do not have facilities for the training of dental personnel.

AFFILIATION OF VA HOSPITALS WITH DENTAL SCHOOLS

The Veterans' Administration has established dentistry as an integral and essential part of its health program. The presence of dental facilities and a full-time staff in every one of the VA's 165 hospitals attests to this fact. An oral examination by a dentist is considered an essential part of a complete physical examination and is one of the most important functions of the Dental Service. The patient and his physician are soon made fully aware of any oral conditions which should receive attention. Some 500 oral malignancies in their early stages have been detected annually over the past several years as a result of hospital dental examinations. These were unnoticed by the patient, and if they had remained untreated, the chances of effecting a cure would have been greatly diminished.

Today the VA hospital system is reaping benefits of many long-standing affiliations with most of America's medical and dental schools. Ninety-five of VA's 165 hospitals are linked in an affiliating relationship to 81 of the nation's medical schools and to 51 of the 53 dental schools. More than 400 colleges, universities, and technical training institutions utilize VA medical and dental staff and facilities in training to help meet the nation's health manpower needs. Approximately 12% of VA dentists hold faculty appointments at one of 51 dental schools with which the VA has established a training affiliation. Additionally, VA dental programs are affiliated with medical schools at Duke University, Vanderbilt University, University of Oklahoma Medical Center, Albany Medical College, Boston University, and the University of Texas Southwestern Medical School.

The VA employs over 700 full-time dentists, and a complement of dental assistants, dental hygienists, and dental laboratory technicians. Dental staffing in our hospitals will vary with such factors as bed capacity and patient turnover. The larger hospitals will staff ten or more dentists, while a single dentist will be found in a few of our smaller hospitals and clinics.

The VA's dental education and training programs not only provide highly competent personnel for patient care, but also contribute to the nation's health manpower needs. The Council on Education of the American Dental Association has approved 46 residency training programs at 25 stations. The VA conducts approximately one-third of all rotating dental internships and one-fifth of all dental residences in affiliation with 51 dental schools. The dental career residency program has been unusually successful in providing shortage category specialists for the Dental Service.

In addition to the training of interns and residents, VA participates in 37 cooperative training programs for dental assistants, 29 in dental hygiene, 7 in dental laboratory technology, and 12 for undergraduate dental students (clinical clerks). The total number of trainees in these latter programs is approximately 3,000 per year.

DENTAL CONSIDERATIONS

There are several areas of dental concern which our Associations believe should receive the Subcommittee's close attention. Our comments are primarily directed towards those provisions of the various bills and resolutions (S. 2219, H.J. Res. 748 and S.J. Res. 76) which are concerned with the use of VA facilities in expanding medical and dental education principally through the establishment of new schools and the expansion of existing affiliated schools.

First, the Veterans' Administration hospital system is in a period of crisis. The most visible elements of the crisis are overcrowding and understaffing. The overriding problem of inadequate funding of VA medical activities has become increasingly evident. Congressional hearings have documented the crisis and how it adversely affects medical care being provided our veterans. These same conditions affecting the quality of medical care can also affect the quality of medical and dental education conducted in VA hospitals which are affiliated with medical and dental schools. Prior to virtually any expansion of Veterans' Administration activities, our Associations recommend that corrective action be taken regarding the critical problems affecting VA medical programs.

Second, our organizations are concerned about the possible fragmentation of responsibility for Federal medical and dental educational policy. The Department of Health, Education and Welfare has the prime responsibility for assistance to medical and dental education. Any attempts to divide this responsibility between various Federal agencies would confuse the schools with a myriad of regulations and objectives. As a minimum, any legislation reported should include the provisions of the Veterans' Administration Health Manpower Training Act. (S. 2219) concerning the coordination of medical programs by the Secretary of HEW and the Administrator of the VA.

Third, the American Dental Association's Council on Education has long been recognized for its specialized accreditation of dental health educational programs and programs for dental hygienist, dental assistant and dental laboratory technician. It has already accredited VA programs in dentistry at the specialty level and recently in their auxiliary training projects. Logical continuation of this theory would insure the highest level of quality dental care from the VA-Dental School program by meeting the appropriate standards of excellence.

Fourth, our organizations are interested in enlarging and complementing the existing dental educational system in order to relieve the dental manpower shortage. In this regard there are presently twenty-two states without operational dental schools. It is our concern that new VA related dental schools be placed so as to relieve the maldistribution of dental personnel under a national plan such as that proposed by the Carnegie Commission on Higher Education.

The questions of location, availability, extent of utilization and possible conversion of VA facilities are difficult to assess, but must be considered in relation to a national plan.

Fifth, our organizations are equally interested in maintaining the high quality of American dental education. The basis of a sound dental program exists in the basic science foundation supplied in a university environment. The academic complex of research laboratories, faculties and graduate students provide a complete atmosphere for assimilation of basic science material. It would be difficult to recruit and transport a basic science system away from a university, and might unjustifiably duplicate the effort. It is urged that the VA hospital dental programs establish close academic affiliation or reasonable proximity to academic medical centers.

OTHER LEGISLATIVE PROPOSALS

The Veterans' Medical Care Act of 1971 (S. 1924):

To provide improved medical care to veterans and to improve recruitment and retention of career personnel in the Department of Medicine and Surgery

The Veterans' Health Care Reform Act (S. 2354):

To upgrade staff ratios of VA hospitals, improve the scope and quality of treatment at VA institutions, stimulate cooperation between VA facilities and community health care programs, and improve recruitment and retention of career personnel in the Department of Medicine and Surgery.

The Veterans' Administration Continuing Medical Education Act (S. 2355):

To provide advanced residency-type training to personnel of the VA and other federal departments and agencies at regional medical centers established at VA hospitals.

The proposals all contain meritorious objectives in their particular area of interest. The broadening and improvement of veteran care, the upgrading of the personnel career system and the expansion of eligible patient categories all are worthwhile and progressive steps in the overall Veterans' program and certainly a vital part of the early implementing of proposed VA medical school programs.

DISABLED AMERICAN VETERANS,
AUGUST 6, 1971.

Hon. ALAN CRANSTON,
Chairman, Subcommittee on Health and Hospitals, Senate Committee on Veterans' Affairs, U.S. Senate, Washington, D.C.

DEAR SENATOR CRANSTON: On behalf of the Disabled American Veterans, I wish to submit the following comments on bills pending before your Subcommittee, which pertain to the Veterans Administration hospital and medical care program.

S. 2219 and H.J. Res. 748 are similar in principle and, in effect, would establish new medical schools, expand the existing VA hospital education and training program, and establish a program of grants to assist VA affiliated medical schools to improve and enlarge their facilities.

The essential aim of the legislation, Mr. Chairman, was made clear in your opening statement at the hearing. You said that "The basic purpose is to utilize to the fullest extent the capacity of Veterans Administration hospitals and other health facilities for the training and education of physicians, dentists, nurses, other health professionals, allied health professionals, and paraprofessionals, and other health manpower."

The DAV recognizes that there is a need for prompt action on this legislation in view of the fact that our nation is, indeed, seriously short of doctors, and the prognosis is far from encouraging. Official Government sources put the national doctor shortage at 50,000. It is reported that even if all the presently planned construction projects, both private and public, were funded and begun at once, the time required to build facilities and train doctors would take six to ten years before the shortage would start easing.

Reports indicate the medical schools across the country are in danger of closing within the next three years because of dwindling funds. In some instances, schools are caught in a money squeeze so severe that expansion of programs and physical plant is out of the question. We are certain that your Committee will see to it that the projects proposed in S. 2219 and H.J. Res. 748 will not fail by reason of a lack of adequate funding.

The health problems of our veterans and the population as a whole are continuing ones. The problem must be tackled promptly and with resolve and unfailing energy. We see in this legislation an opportunity for the Veterans Administration, through its medical program, to enlarge its already substantial contribution to the health needs of veterans and the nation. Accordingly, the Disabled American Veterans is pleased to support this very practical legislative proposal.

S. 2354, another pending bill, would among other things, authorize VA hospital and medical care for the widows and children of veterans who died of service-connected causes, and for wives and children of veterans who have service-connected disabilities rated as permanently and totally disabling. This provision of the bill, if enacted, satisfies a resolution adopted by our most recent National Convention. The furnishing of this care would be wholly subject to the priorities set down for the care of veterans under present law.

As you know, Mr. Chairman, under terms of the Military Medical Benefits Act, hospital care is made available to dependents of retired military personnel and to the widows and children of servicemen who die while on active duty.

It is our feeling that the dependents of totally disabled service-connected veterans, and the survivors of veterans who die from service-connected causes, should be placed in a position comparable to that enjoyed by dependents of military retirees.

Your Committee and the Congress have consistently recognized that the widow of a man who dies of service-incurred diseases or injury is in a special category, and one to which the nation owes a special debt. This is reflected in the passage of legislation that has established programs of death compensation payments, provisions for home loans, and for educational assistance benefits to widows and war orphans. We believe that authorization for hospital and medical benefits would be a logical and natural progression of a grateful nation's efforts to fulfill in a greater degree the needs of survivors of those who contribute so much to preserve America's security in time of war.

In closing, Mr. Chairman, I want to say that the DAV is most grateful to you and the members of your Subcommittee for your firm and persevering efforts to improve the quality of care and treatment in VA hospitals. Not only veteran patients, but all sick and disabled can be thankful for the support this Committee has given to the development of the educational, medical, and prosphetic research programs carried out in VA hospitals and clinics, and those under VA sponsorship outside their own facilities.

The long and specialized experience the VA has acquired over the years is very well placed to propose, foster, and coordinate these important projects. We know that your Committee will do its best to see that funds for space, equipment, and personnel are available to enable the VA to carry on these essential functions.

Sincerely,

CHARLES L. HUBER,
National Director of Legislation.

PARALYZED VETERANS OF AMERICA, INC.,
Washington, D.C., August 19, 1971.

Senator ALAN CRANSTON,
U.S. Senate,
Washington, D.C.

DEAR SENATOR CRANSTON: I am pleased to respond to your request for a statement for the record by the Paralyzed Veterans of America, regarding S. 2354, "Veterans Health Care Reform Act of 1971."

First, I congratulate you for having the foresight to introduce such a comprehensive bill which will, on balance, tremendously improve the care for veterans, their dependents, widows and survivors, provided by the Veterans Administration. I trust this bill will receive widespread wholehearted support by all veterans, veterans' groups and the Administration.

Dealing with the specifics of the bill, it becomes immediately apparent that many of these reforms have been needed for a long time. Providing treatment for the disabled veterans' family and the all important orientation instruction to newly injured patients' families is something that has been sadly lacking and desperately needed, especially for the totally disabled. The family, not just the patient, has suffered the catastrophe with which it must now learn to deal. We never should have, and certainly no longer should, allow the training and orientation to be a hit or miss policy. It is not a one-sided affair, for if the family can be oriented, then they may help to educate the community to the needs of these handicapped, but not helpless, young men.

Hospital based home care has begun as a pilot project within the Veterans Administration, at two of twelve Spinal Cord Injury Centers. It is imperative that it be funded to continue and expand for it is the real hope in aiding the individuals who need special attention to return to society and not inhabit our hospitals. The pilot results thus far have been encouraging. We sincerely hope that expansion will take place as soon as is practicable.

We applaud your efforts to include closer ties to more medical schools whether they have hospitals or not and believe that empty VA beds should be utilized as long as the care to the veteran is not jeopardized by such use. The veteran is the charge of the VA and should rightly remain so. His needs and those of his dependents should remain the paramount task of the VA Hospital System.

The PVA has been advocating higher incentives for nurses and paramedical personnel for some time. These incentives must be of the "now" variety and not a promise of retirement twenty years hence. Shift differential pay is a primary tool to provide the competitive recruitment by the VA in the nursing field. Granted, as in any profession related to health, there are manpower difficiencies, but the VA could hire their fair share of the available personnel, if they could compete in incentives offered. The long range effect would be a higher enrollment in nursing programs if the individuals knew that jobs with proper pay and incentives were waiting. The range of this is not as long as it first seems, since the two year degree is becoming the most popular program for nurses.

Providing hospital and outpatient care either through VA facilities or on a fee-pay basis to recipients of DIC benefits and dependents of living, totally disabled veterans, is a recognized need and is a sensible way of relieving a costly burden to the veteran or his survivors in a most economic fashion. Finally, the importance of treating the "whole" patient cannot be stressed enough. One may not assume renal dysfunction would occur in a given individual had a wound not caused some other unrelated disability. It simply cannot be assumed, since it would be at best a speculation, and at worst, an attempt at sooth-saying. All of the patient must be comprehensively treated without particular regard as to whether the problem can be directly traced to a service-connected disability.

Thank you for this opportunity to comment for the record on S. 2354. We hope for a speedy passage so that the comprehensive measures contained in it may be quickly implemented. S. 2354 has our wholehearted support.

Sincerely yours,

MICHAEL W. BURNS,
Executive Director.

NEW YORK UNIVERSITY,
NEW CAREERS TRAINING LABORATORY,
New York, N.Y., September 2, 1971.

SENATOR ALAN CRANSTON,
Chairman, Subcommittee Health and Hospitals, Veterans' Affairs Committee, Senate Office Building, Washington, D.C.

DEAR SENATOR CRANSTON: Thank you for your kind invitation to comment upon S. 2354, the Veterans Health Care Reform Act of 1971.

The bill is a major step forward in the health care for veterans and their families, and indirectly for all Americans in the precedents it sets and models it establishes. Among the central features of the bill which merit special note is the consideration of the veteran in his family context as part of his mental health care; the expansion of care to give a prime role to home nursing, and ambulatory care which is both preferable to and less costly than sole reliance on in-hospital care; consideration of the full range of a veteran's health needs rather than an artificial parcelling out of service-connected and non-service illnesses; and, of course, the improvements in personnel systems.

The inclusion of a broader range of health personnel and provision for a more appropriate salary range are both important steps. We are particularly impressed with the provisions of Title II, Section 201 as relates to the utilization of the full range of health personnel. For too long, our nation's health system has been shackled by arbitrary and irrelevant patterns of manpower utilization.

It is noteworthy that not only does the section provide for the reassignment of tasks among various members of the health team, but that it takes the next necessary steps to make that reassignment a reality by provision for the establishment of new positions, by the provision of continuing education, and by the emphasis on career mobility.

In the current discussions regarding the development of such new jobs as physician's assistant, we have been troubled by the proclivity to restrict admission to training programs for this position to those who have had military service. While the waste to civilian health care of the failure to use persons trained in health care in the military was and is a serious problem, it seems to us that restricting programs such as those for physician's assistants to former servicemen only created other serious problems. Among other matters, it continued the sexism which characterizes the medical profession by eliminating from consideration for physician's assistants positions civilian nurses, the vast majority of whom are women, while admitting former corpsmen and the like, the vast majority of whom are men. We are pleased, therefore, that the bill places no restrictions upon the nature of the previous experience required by persons who would be trained to become physician's assistants.

Another concern which we have had in the rapid adoption of physician's assistants programs is that they would become yet another special job in the health field, unrelated to other positions with access to it limited and opportunities for career development beyond it limited. While there is nothing in the language of the bill which imposes such restrictions, it may well be desirable (either in Committee action or from the floor) to make clear the intention to assure full career mobility to and from all positions in the personnel system of the Veterans Administration Department of Medicine and Surgery.

We spoke, at the beginning of this statement, of the precedents set and models provided by this bill for health care among the broader population. We hope that many of the ideas included here—such as consideration of the individual patient in the context of his family (and community, too); emphasis on ambulatory, nursing and home care, as well as in-hospital service; consideration of the patient's full health needs including physical, mental and dental care; a more flexible personnel system with emphasis on new roles for improved service delivery, as well as provision of continuing education as a part of the job and full career mobility—will not only appear in the work of the Veterans Affairs Committee but will also be carried to the consideration of national health insurance programs by the Labor and Public Welfare Committee.

Sincerely yours,

FRANK REISSMAN,
Director.
ALAN GARTNER,
Associate Director.

BAYLOR COLLEGE OF MEDICINE,
Houston, Tex., December 3, 1971.

Hon. ALAN CRANSTON,
U.S. Senate,
Washington, D.C.

MY DEAR SENATOR CRANSTON: Your introduction of Senate Bill 2219, entitled "Veterans Administration Health Manpower Training Act of 1971", represents a great step forward in helping meet the health manpower shortage in the United States. The Veterans Administration, which operates the largest medical health care system in the country, should be more effectively utilized than it has been in the past in health manpower production. I believe the Bill which you have introduced in the Senate assures us that this will be accomplished.

I strongly support this legislation and earnestly hope that it will receive the overwhelming support of the Senate.

With best wishes, I am

Sincerely,

MICHAEL E. DE BAKEY, M.D.

NATIONAL FEDERATION OF FEDERAL EMPLOYEES,
Washington, D.C., January 24, 1972.

Hon. VANCE HARTKE,
Chairman, Senate Committee on Veterans Affairs,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR HARTKE: We have been informed that your committee will be meeting in executive session on February 3, 1972, to consider, among other bills, S. 2354, S. 1635, and H.R. 10880. We would like to make known our views on these bills so as to place them in the record for consideration by your committee.

Our interest in the subject of these bills extends, in particular, to one chapter, which provides for the payment of differential for certain time spent working by nurses employed by the Department of Medicine and Surgery. We are of the opinion that these differentials should be provided not solely to registered nurses, but also to licensed vocational nurses, and nursing assistants. We offer our views from a position of being the exclusive representative for numerous units of nurses in the Veterans Administration, and from having been granted national consultation rights by the Veterans Administration.

We applaud the introduction of both S. 1635 and S. 2354 by Senator Moss, and Cranston, respectively, as going a long way to doing justice to our nursing staff in the Veterans Administration.

We endorse a 15% differential of the hourly rate for hours spent on the evening or night tours of duty. The Veterans Administration has long had difficulty in finding nurses to work the second and third shifts in the hospitals. As a result, scheduling of those nurses employed at a hospital, is much more difficult. By providing for a night differential, it will serve as an attraction for more qualified persons to apply to be registered nurses, licensed vocational nurses, or nursing assistants, thus alleviating this problem.

The National Federation of Federal Employees is also in favor of a 30% differential for work on either Saturday or Sunday. Neither of these days are part of the ordinary work week, but are viewed as days of rest and relaxation. There is no reason to distinguish between Saturday and Sunday, in assigning a pay differential for work. One of the provisions missing from H.R. 10880 is such a differential for Saturday work. We hope that your committee will see fit as to compensate a nurse or nursing assistant additionally for work on either Saturday or Sunday.

All three bills provide for differentials for work on federal legal holidays and overtime work. This is properly so. We agree with the amount of differential provided.

One provision of Senator Moss' bill is conspicuously absent from H.R. 10880 and S. 2354. This is the allowance of differential pay for time spent while on standby or on-call status. This is long overdue. Most nurses and nursing assistants find that their private lives are that much less private, in that they must always be available to report to their hospital when needed. This resricts sharply their manner of movement. The least that this committee and Congress can do is compensate these employees for the sacrifice we ask of them.

These provisions will promote the efficiency of the Veterans Administration. They will make it more conducive for the Veterans Administration to attract top qualified personnel in the nursing service and to keep them after they are trained.

We ask much of our nurses and nursing assistants. The pressures on them are great. Their responsibility is great. The restrictions on them are great. It is not too much to ask that employees of the nursing service be justly compensated for these sacrifices.

We wish to add one further comment. While we applaud the features of these three bills, we would urge Congress to provide such pay differentials for nurses throughout the federal service, not just those employed by the Veterans Administration. We believe in equity across the board.

Thank you for the opportunity to make our views a part of the record.

Sincerely,

N. T. Wolkomir, *President*.

APPENDIX A

92d Congress
1st Session } HOUSE COMMITTEE PRINT NO. 3

TRAINING OF HEALTH SERVICE PERSONNEL IN THE VETERANS' ADMINISTRATION

FEBRUARY 22, 1971

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INDEX

VA HOSPITALS AND OUTPATIENT CLINICS

Page
Summary, fiscal year 1970 ---- 1
Alabama:
  Birmingham ---- 3
  Montgomery ---- 4
  Tuscaloosa ---- 4, 5
  Tuskegee ---- 5, 6
Alaska: Juneau ---- Negative
Arizona:
  Phoenix ---- 6
  Prescott ---- 6, 7
  Tucson ---- 7
Arkansas:
  Fayetteville ---- 8
  Little Rock ---- 8, 9
California:
  Fresno ---- 9
  Livermore ---- 9, 10
  Long Beach ---- 10, 11
  Los Angeles ---- 12, 13
  Los Angeles Outpatient Clinic ---- 14
  Martinez ---- 14, 15
  Palo Alto ---- 15, 16
  San Fernando ---- 17
  San Francisco ---- 17, 18
  Sepulveda ---- 19
Colorado:
  Denver ---- 20
  Fort Lyon ---- 20
  Grand Junction ---- 20, 21
Connecticut:
  Newington ---- 21
  West Haven ---- 22
Delaware: Wilmington ---- 24
District of Columbia: Washington ---- 23
Florida:
  Bay Pines ---- 24
  Gainesville ---- 25
  Lake City ---- 25, 26
  Miami ---- 26, 27
Georgia:
  Atlanta ---- 27, 28
  Augusta ---- 28, 29
  Dublin ---- 29, 30
Hawaii: Honolulu ---- 30
Idaho: Boise ---- 30
Illinois:
  Chicago (Research) ---- 31
  Chicago (West Side) ---- 31, 32
  Danville ---- 32
  Downey ---- 33
  Hines ---- 33, 34
  Marion ---- 35

Page

Indiana:

Fort Wayne 35
Indianapolis 35, 36
Marion 36

Iowa:

Des Moines 37
Iowa City 37, 38
Knoxville 38

Kansas:

Topeka 39
Wadsworth 40
Wichita 40

Kentucky:

Lexington 41
Louisville 41, 42

Louisiana:

Alexandria 42
New Orleans 42, 43
Shreveport 43
Maine: Togus 43, 44

Maryland:

Baltimore 44
Fort Howard 44
Perry Point 45

Massachusetts:

Bedford 45, 46
Boston 46, 47
Boston Outpatient Clinic 47
Brockton 47, 48
Northampton 48
West Roxbury 49

Michigan:

Allen Park 49
Ann Arbor 50
Battle Creek 50, 51
Iron Mountain 51
Saginaw 51

Minnesota:

Minneapolis 52, 53
St. Cloud 53

Mississippi:

Biloxi 54
Jackson 54, 55

Missouri:

Jefferson Barracks 55
Kansas City 56
Poplar Bluff 57
St. Louis 57

Montana:

Fort Harrison Negative
Miles City 58

Nebraska:

Grand Island 58
Lincoln 53
Omaha 59
Nevada: Reno 59
New Hampshire: Manchester 60

New Jersey:

East Orange 60, 61
Lyons 61
New Mexico: Albuquerque 62

New York:

Albany 62, 63
Batavia 63
Bath 64
Bronx 64, 65
Brooklyn 65, 66

New York—Continued

Page

  Brooklyn Outpatient Clinic 66
  Buffalo 67
  Canandaigua 67
  Castle Point 67, 68
  Montrose 68
  New York 69, 70
  New York Prosthetics Center 70
  Northport 70, 71
  Syracuse 71, 72

North Carolina:

  Durham 72, 73
  Fayetteville 73, 74
  Oteen 74
  Salisbury 75
North Dakota: Fargo 76

Ohio:

  Brecksville 76
  Chillicothe 77
  Cincinnati 77, 78
  Cleveland 78, 79
  Dayton 79

Oklahoma:

  Muskogee 80
  Oklahoma City 80, 81

Oregon:

  Portland 82
  Roseburg 82, 83
  White City 83

Pennsylvania:

  Altoona 83
  Butler 83, 84
  Coatesville 84
  Erie 85
  Lebanon 85
  Philadelphia 86
  Philadelphia Outpatient Clinic 87
  Pittsburgh General 87, 88
  Pittsburgh Psychiatric 88, 89
  Wilkes-Barre 89
Philippines: Manila 90
Puerto Rico: San Juan 90
Rhode Island: Providence 91

South Carolina:

  Charleston 91, 92
  Columbia 92

South Dakota:

  Fort Meade 92
  Hot Springs 93
  Sioux Falls 93

Tennessee:

  Memphis 94
  Mountain Home 95
  Murfreesboro 96
  Nashville 97

Texas:

  Amarillo 98
  Big Spring .... Negative
  Bonham .... Negative
  Dallas 98, 99
  Houston 99, 100
  Kerrville 100, 101
  Lubbock .... Negative
  Marlin .... Negative
  San Antonio 101
  Temple 101, 102
  Waco 102

Page
Utah: Salt Lake City 103
Vermont: White River Junction 104

Virginia:

Hampton 104
Richmond 105
Salem 106

Washington:

American Lake 107
Seattle 107, 108
Spokane 109
Vancouver 109
Walla Walla 110

West Virginia:

Beckley 110
Clarksburg 110, 111
Huntington 111
Martinsburg 112

Wisconsin:

Madison 112, 113
Tomah 113
Wood 114, 115

Wyoming:

Cheyenne 115
Sheridan 116

FOREWORD

As authorized by Public Law 89–785, November 7, 1966 the Veterans' Administration Department of Medicine and Surgery hospitals and outpatient clinics participate in the training of persons for the health services field. During fiscal year 1970, more than 49,000 persons received training through the Veterans' Administration in 125 different health services programs and subprograms. The number included 21,550 physicians; 1,359 dentists; and 26,142 trainees in the allied and administrative health fields.

Many VA hospitals and outpatient clinics have indicated that they have the capability of expanding or beginning new allied and administrative health training programs if the necessary additional funds were provided for trainee stipends, instructor salaries, space modification and other pertinent costs. More than 12,000 additional trainees can be accommodated in the VA system by September 1971, if such funds were made immediately available.

The data that follow show for each VA hospital and outpatient clinic arranged alphabetically within State, the health services training program accomplishments in fiscal year 1970 (I) and their potential expansion by September 1971 (II).

The committee believes that the Veterans' Administration's Department of Medicine and Surgery has a unique capability for the training of health services personnel, a resource which is not available at any other centralized organization in the United States. We hope that this program will be funded at such a level as to at least provide some relief to the great shortages which already exist in the health services field.

The committee is indebted to Dr. Benjamin J. Lewis, Silvio Cappiello, and Mary Ann Fink of the VA Department of Medicine and Surgery Education Service; and to the always efficient and cooperative Mr. Bernard Kaufman and his assistant, Theresa D. Billingslea, of the Department's Reports and Statistics staff. Without their help this compilation would not be possible.

OLIN E. TEAGUE,
Chairman.

SUMMARY, VA HEALTH SERVICES TRAINING PROGRAMS, FISCAL YEAR 1970

Category	Number		
	Paid	Without compensation	Total
Grand total	12,090	36,961	49,051
Physician training (total)	8,424	13,126	21,550
Electromyogram physician trainee		3	3
Medical intern	1,332	287	1,619
Medical resident (career)	288		288
Medical resident (noncareer)	6,720	1,056	7,776
Medical student		11,699	11,699
Medical student, anesthesiology	25	2	27
Nuclear medicine physician trainee		2	2
Osteopathy student		64	64
Research and education trainee	59	13	72
Dentist training (total)	260	1,099	1,359
Dental intern (career)	32		32
Dental intern (noncareer)	73	4	77
Dental resident (career)	42		42
Dental resident (noncareer)	102	34	136
Dental student		1,059	1,059
Dental student (in graduate training)		1	1
Dental student summer research trainee	11	1	12
Allied health training (total)	3,166	22,619	25,785
Audiology and speech pathologist (in doctoral training)	102	19	121
Audiology and speech pathologist (in master's degree training)	126	157	283
Audiology and speech pathologist (in baccalaureate degree training)		43	43
Biochemist (in graduate and postdoctoral training)	1	7	8
Blind rehabilitation specialist		36	36
Cardiopulmonary technician		4	4
Chaplain resident	9	23	37
Dental auxiliaries:			
Dental assistant	6	531	537
Dental hygienist	64	643	707
Dental laboratory technician	9	53	62
Dietetics:			
Dietetic intern	152	156	308
Dietetic resident	1	1	2
Dietetic student		123	123
Food service worker		53	53
Hospital cook		1	1
Electrocardiograph technician		5	5
Electroencephalograph technician	11	6	17
Gastroenterology technician	4		4
Hospital librarian:			
Hospital librarian (in master's degree training)	32		32
Hospital librarian (in baccalaureate degree training)		14	14
Inhalation therapist	13	69	82
Medical illustration:			
Biomedical photographer		3	3
Medical illustration artist		1	1
Medical laboratory:			
Certified laboratory assistant	53.	45	96
Cytotechnologist	1	22	23
Histologic technician	10	13	23
Medical technician	21	69	90
Medical technologist	237	131	368
Metabolic technician	1		1
Microbiologist (in graduate training)		3	3
Nuclear medicine:			
Nuclear medicine technician	1	4	5
Nuclear medicine technologist	10	3	13
Nursing:			
Basic nurse student		14,093	14,093
Graduate nurse student		290	290
Nursing intern	2	7	9
Practical nurse student		2,746	2,746
Professional nurse (refresher training)		262	262
Paramedical services orientation (nursing home employees and college, high school, and vocational students)		55	55
Pathology:			
Autopsy assistant	3		3
Pathologist's assistant	5		5

SUMMARY, VA HEALTH SERVICES TRAINING PROGRAMS, FISCAL YEAR 1970

Category	Number		
	Paid	Without compensation	Total
Pharmacy:			
Pharmacy assistant	19	1	20
Pharmacy intern	42		42
Pharmacy resident	36	11	47
Pharmacy student		448	448
Radiopharmacy student		2	2
Physician's assistant	2	2	4
Physical medicine and rehabilitation:			
Corrective therapist		135	135
Corrective therapist assistant		9	9
Educational therapist		5	5
Manual arts therapist		28	28
Occupational therapist	327	150	477
Occupational therapist assistant		46	46
Physical medicine and rehabilitation student		16	16
Physical therapist	4	574	578
Physical therapist assistant		36	36
Recreation specialist		88	88
Podiatry:			
Podiatry intern		1	1
Podiatry student		52	52
Prosthetics:			
Orthotist-prosthetist	12	1	13
Prosthetic representative	4		4
Restoration technician	2		2
Psychology:			
Clinical and counseling psychologist (in doctoral training)	967	249	1,216
Clinical and counseling psychologist (in postdoctoral training)	20	5	25
Psychology student (in baccalaureate degree training)		105	105
Vocational rehabilitation counselor (in master's degree training)		64	64
Radiology:			
Radiation therapy technologist		7	7
Radiologic technician		37	37
Radiologic technologist	217	263	480
Radiologist's assistant	2		2
X-ray film processor	4	1	5
Research and clinical assistant (in various disciplines)		38	38
Social work:			
Clinical social science student	12	3	15
Social worker (in doctoral training)	10	4	14
Social worker (in master's degree training)	524	203	727
Social worker assistant (non-academic, for holders of baccalaureate degree)		12	12
Social worker student (in baccalaureate degree training)		254	254
Surgical:			
Nurse-anesthetist	62	17	79
Operating room technician		31	31
Ophthalmology technician		2	2
Surgeon's assistant	8	2	10
Surgery technician (general)		17	17
Urology technician	2		2
Veterinary medicine:			
Animal facilities research supervisor	6		6
Veterinary medical resident investigator	10		10
Veterinary student		4	4
Administrative training (total)	240	117	357
Accountant	26		26
Administrative intern	1	1	2
Assistant hospital director	24		24
Associate chief nurse, nursing education	5		5
Building management officer	20		20
Central service technician		9	9
Chaplain orientation	17		17
Chief nurse	10		10
Chief of staff	3		3
Director, voluntary service	2		2
Graduate engineer	11		11
Graduate hospital administration	4	1	5
Hospital administration resident	8	17	25
Hospital director	2		2
Laundry superintendent	5		5
Management analyst	7		7
Medical administration	8		8
Medical assistant	8	2	10
Medical record librarian	5	59	64
Medical record technician		19	19
Medical secretary		7	7
Personnel management specialist	57		57
Rehabilitation administration		2	2
Supply management	17		17

3

BIRMINGHAM, ALA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	166	
Medical intern	44	
Career psychiatry resident	2	
Career neurosurgery resident	1	
Career pathology resident	2	
Dental resident (noncareer)	16	
Career dental resident	3	
Medical student 2d 2 school years	83	University of Alabama School of Medicine, Birmingham, Ala.
Dental student 2d 2 school years	52	University of Alabama School of Dentistry, Birmingham, Ala.
Dental laboratory technician trainee	4	Do.
Basic nursing student	397	St. Vincent's Hospital, Birmingham, Ala.; University of Alabama School of Nursing, Birmingham, Ala. Jefferson State Junior College, Birmingham, Ala.
Graduate nursing student	4	University of Alabama School of Nursing, Birmingham, Ala.
Audiology and speech pathology student (doctoral).	1	University of Alabama, Tuscaloose, Ala.
Audiology and speech pathology student (master's).	5	Auburn University, Auburn, Ala. Montevallo University, Syracuse University, Syracuse, N.Y.
Social work student (master's)	4	University of Alabama, Tuscaloosa, Ala.; Atlanta University, Altanta, Ga.
Corrective therapy assistant trainee	8	Samford University, Birmingham, Ala.
Pharmacy student	4	Samford University School of Pharmacy, Birmingham, Ala.
Dietetic intern affiliate	8	University of Alabama, Birmingham, Ala.
Medical technologist student	21	Do.
Cytotechnologist student	8	Do.
Histologic or histopathology technician trainee	4	
Pathologist's assistant trainee	1	
Radiologic technologist trainee	40	University of Alabama, Birmingham, Ala.
X-ray film processor trainee	4	
Nurse-anesthetist trainee	30	University of Alabama, Birmingham, Ala.
Nuclear medicine technician trainee	4	
Surgeon's assistant trainee	8	University of Alabama School of Medicine, Birmingham, Ala.
Research and education trainee	1	Do.
Graduate hospital administration trainee	1	
Assistant hospital director trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
Dental laboratory technician	$20,380	$3,080	$8,000		$9,300	1
Audiology and speech masters	17,640	6,640	11,000			2
Audiology and speech reinforcement therapy	49,600	10,600	14,000		25,000	6
Occupation therapy	57,400	9,900	11,000	$25,000	11,500	4
Physical therapy	63,900	9,900	12,000	25,000	17,000	4
Pharmacy residents	28,100	9,900	12,302		5,000	4
Food service workers	31,600	21,680	9,886		100	20
Medical technician	85,500	42,000	27,500		34,000	10
Cytology technician	54,631	24,750	9,881		20,000	10
Certified laboratory assistant	10,000	10,000	(1)		(1)	20
Pathology assistant	43,985	13,344	9,881		20,760	3
X-ray technician						
Inhalation therapy	24,880	9,900	4,980		10,000	4
Physician assistant	230,250	72,000	75,750		55,500	24
Surgeon's assistant	59,600	30,000	15,000	5,000	9,600	10
Electron microscope	69,900	9,900	32,000	5,000	23,000	4

[1] Included in medical technician.

MONTGOMERY, ALA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	34	St. Margaret's Hospital, School of Nursing, Montgomery, Ala.
Social work student (master's)	2	University of Alabama, Tuscaloosa, Ala.
Pharmacy student	10	Auburn University, Auburn, Ala.
Surgeon's assistant trainee	2	University of Alabama Medical School, Birmingham Ala.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Social work student (masters)	$6,800	$6,800				2
Social work student (undergrad)	13,500	(1)	$13,000	$500		2
Total	20,300	6,800	13,000	500		4
New programs: Pharmacy interns (agreement with State)	17,100	16,200	900			2
Grand total	37,400	23,000	13,900	500		6

TUSCALOOSA, ALA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	249	Ida V. Moffett School of Nursing, Birmingham, Ala. Druid City Hospital School of Nursing, Tuscaloosa, Ala. Mobile Infirmary School of Nursing. Mobile. Ala. St. Margarets School of Nursing, Montgomery, Ala. St. Vincent Hospital School of Nursing, Birmingham, Ala. Sylacauga Hospital School of Nursing, Sylacauga, Ala. Jefferson State Junior College, Birmingham, Ala.
Practical nurse student	91	Shelton State Technical Institute, Tuscaloosa, Ala. Tuscaloosa State Trade School, Tuscaloosa, Ala. Bessemer State Trade School, Bessemer, Ala. Colbert County Hospital, Colbert County, Ala. Muscle Shoals Mental Health Association, Muscle Shoals, Ala.
Psychlolgy student (graduate)	11	University of Alabama, Tuscaloosa, Ala.
Social work student (master's)	10	Atlanta University, Atlanta, Ga.
Social work student (baccalaureate)	5	Mississippi State College for Women, Columbus, Miss.
Manual arts therapist student	6	University of Alabama, Tuscaloosa, Ala.
Recreation specialist student	6	Do
Associate chief nurse, nursing education, trainee	1	
Account nt trainee	2	Do.
Building mamagement officer trainee	1	

TUSCALOOSA, ALA.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Basic nursing student baccalaureate	$106,114	None	$51,114	$15,000	$40,000.00	35
Practical nurse student	29,582	None	25,557	-----------	4,025.00	15
Social work student (masters degree training)	19,920	19,920	None	None	-----------	6
Social work student (baccalaureate training)	13,280	13,280	None	None	-----------	4
Total	168,896	33,200	76,671	15,000	44,025.00	60
NEW PROGRAMS						
Graduate nursing student (master's degree)	1,000	None	None	None	1,000	10
Occupational therapist student (baccalaureate or higher training)	15,849	4,980	10,869	None	None	6
Mental health associate (junior college or baccalaureate training)	43,081	33,200	9,881	None	None	10
Total	59,930	38,180	20,750	None	1,000	26
Grand total	228,826	71,380	97,421	15,000	45,025	86

TUSKEGEE, ALA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	7	
Basic nursing student	135	Albany State College, Albany, Ga.; Tuskegee Institute, Tuskegee, Ala.
Psychology student (baccalaureate)	3	Auburn University, Auburn, Ala.
Social work student (master's)	9	Florida State University, Tallahassee, Fla.; University of Alabama, Tuscaloosa, Ala.
Corrective therapist student	20	Tennessee A. & I. University, Nashville, Tenn.; Texas Southern University, Houston, Tex.; Florida A. & M. University, Tallahassee, Fla.; Harding College, Searcy, Ark.; Tuskegee Institute, Tuskegee, Ala.; Alabama State University, Montgomery, Ala.; Southern University, Baton Rouge, La.
Recreation specialist student	8	Tennessee, A. & I. University, Nashville, Tenn.; Texas Southern University, Houston, Tex.; Florida A. & M. University, Tallahassee, Fla.; Tuskegee Institute, Tuskegee, Ala.; Southern University, Baton Rouge, La.
Pharmacy student	3	Auburn University, Auburn, Ala.
Dietetic intern affiliate	7	Tuskegee Institute, Tuskegee, Ala.
Dietetic student	18	Do.

TUSKEGEE, ALA.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
Expandable programs: Social work stupent (in master's degree training) (total)	$33, 122	$18, 930	$14, 192	0	0	6
New programs:						
Pharmacy interns	75, 214	15, 500	43, 214	0	0	2
Pharmacy resident		16, 500		0	0	2
Medical technologist	21, 200	21, 200	0	0	0	5
Radiology technician trainee	14, 598	0	14, 598	0	0	6
Total	111, 012	53, 200	57, 812	0	0	15
Grand total	144, 134	72, 130	72, 004	0	0	21

PHOENIX, ARIZ.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medica lresident (noncareer)		
Medical intern	1	
Basic nursing student	36	Arizona State University, Tempe, Ariz.
Psychology student (graduate)	13	Arizona State University, Tempe, Ariz., University of Arizona, Tucson, Ariz.
Social work student (master's)	6	Arizona State University, Tempe, Ariz.
Social work student (baccalaureate)	1	Do.
Medical illustration artist	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipend	Instructor salaries	Space	Other costs	
NEW PROGRAMS						
Pharmacy interns	$17,000	$17, 000	None	None	None	2

PRESCOTT, ARIZ.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	11	Yavapai College, Prescott, Ariz.
Manual arts therapist student	1	Northern Arizona University, Flagstaff, Ariz.

PRESCOTT, ARIZ.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Associate degree nursing program (affiliated) (total)	$16,000	(1)	$16,000	0	0	12
NEW PROGRAMS						
Dental assistant	4,621	4,621	0	-----------	0	1
EKG technician	4,621	4,621	0	0	0	1
Food service supervisor or manager (affiliated)	5,000	-----------	0	-----------	$5,000	1
Dietetic intern	6,548	6,548	0	-----------	500	1
Social work service student in MSW	18,845	6,440	11,905	0	-----------	2
Social work service assistant trainee at BA level to assist social worker	13,096	13,096	-----------	0	-----------	2
Certified laboratory assistant	28,105	23,105	9,881	-----------	5,000	5
Graduate engineer trainee	6,548	6,548	0	0	0	1
Personnel management specialist trainee	6,548	6,548	0	0	0	1
Supply management trainee	6,548	6,548	0	0	0	1
Graduate hospital administrator trainee	8,098	8,098	0	0	0	1
Nursing assistant trainee	92,420	92,420	0	0	0	20
Operating room technician	7,621	4,621	0	0	3,000	1
LPN (affiliated)	0	(1)	0	0	0	20
Total	222,000	183,214	25,286	-----------	13,500	58
Grand total	238,000	183,214	41,286	-----------	13,500	70

TUCSON, ARIZ.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncarreer)	15	
Medical student 1st 2 school years	96	University of Arizona College, of Medicine, Tucson, Ariz.
Medical student 2d 2 school years	32	Do.
Basic nursing student	167	University of Arizona, Tucson Ariz.
Practical nurse student	68	MDTA, Tucson, Ariz.
Audiology and speech pathology student (master's).	2	University of Arizona, Tucson, Ariz.
Psychology student (graduate)	11	Do.
Psychology student (postdoctorial)	1	Do.
Social work student (master's)	3	Arizona State University, Tucson, Ariz.
Pharmacy student	13	University of Arizona, Tucson, Ariz.
Dietetic student	5	Do.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Audiology and speech pathology student	$3,890	$3,890	0	0	0	1
NEW PROGRAMS						
Dental assistant trainee	0	0	0	0	0	2
Dental laboratory technician trainee	0	0	0	0	0	1
Professional nurse trainee	11,905	0	$11,905	0	0	6
Occupational therapy student	0	0	0	0	0	1
Physical therapy student	0	0	0	0	0	1
Cytology technician student	0	0	0	0	0	1
Radiologic technician trainee	10,800	10,800	0	0	0	4
Inhalation therapy technician trainee	11,905	0	11,905	$12,000	$2,000	5
Cardiopulmonary technician trainee	0	0	0	0	0	1
Total	34,610	10,800	23,810	0	0	24
Grand total	38,500	14,690	23,810	12,000	2,000	24

FAYETTEVILLE, ARK.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Social work student (baccalaureate)	1	University of Arkansas, Fayetteville, Ark.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
NEW PROGRAMS						
Nursing assistant trainee	$45,185	$33,280	$11,905	0	0	10
Social work student (in M.S. degree program)	6,640	6,640	0	0	0	2
Social work student (in baccalaureate training)	0	0	0	0	0	2
Social work assistant trainee (holder of bachelor's degree in training at VA station to assist social worker	5,980	5,980	0	0	0	2
Pharmacy intern	8,098	8,098	0	0	0	1
Dietetic intern affiliate (student from non-VA internship)	13,095	13,095	0	0	0	2
Food service worker trainee (all levels)	13,312	13,312	0	0	0	4
Technical trainee	3,328	3,328	0	0	0	1
Total	95,638	83,733	11,905	0	0	24

LITTLE ROCK, ARK.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	94	
Medical intern	38	
Career psychiatry resident	2	
Career anesthesiology resident	1	
Career pathology resident	5	
Medical student 2d 2 school years	106	University of Arkansas School of Medicine, Little Rock, Ark.
Dental hygienist trainee	20	University of Arkansas School of Dental Hygiene, Little Rock, Ark.
Basic nursing student	208	St. Vincents Infirmary, Little Rock, Ark.; State College of Arkansas, Conway, Ark.; University of Arkansas School of Nursing, Little Rock, Ark.
Psychology student (graduate)	14	University of Missouri, Columbia, Mo.; University of Arkansas, Fayetteville, Ark.; University of Tennessee, Knoxville, Tenn.
Social work student (master's)	17	University of Arkansas School of Social Work, Little Rock, Ark.; Louisiana State University School of Social Work, Baton Rouge, La.
Social work student (baccalaureate)	6	A.M. & N. College, Pine Bluff, Ark.
Manual arts therapist student	2	State College of Arkansas, Conway, Ark.
Medical technologist student	6	University of Oklahoma, Norman, Okla., A.M. & N. College, Pine Bluff, Ark.
Medical student anesthesiology trainee	2	University of Arkansas School of Medicine, Little Rock, Ark.
Chief nurse trainee	1	
Personnel management specialist trainee	1	

LITTLE ROCK, ARK.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
NEW PROGRAMS						
Operating room technicians	$95, 909	$55, 452	$32, 440		$8, 017	12
Social work student (in master degree training)	$6, 725	$6, 400			$325	4
Social work student (in baccalaureate training)	21, 496	6, 000	14, 192		1, 304	22

FRESNO, CALIF

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	3	
Basic nursing student	76	Fresno State College, Fresno, Calif.
Graduate nursinng student	3	Do.
Social work student (master's)	3	Do.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Dental assistant trainee	$21, 285	0	$21, 285	0	0	4
Social work student	31, 722	$17, 940	12, 932	$850	0	6
Total	53, 007	17, 940	34, 217	850	0	10
NEW PROGRAMS						
Dietetic interne			0	0	0	11
Practical nurse student	13, 846	0	13, 846	0	0	16
Total	13 846	0	13 846	0	0	16

LIVERMORE, CALIF.,

I. FISCAL YEAR 1970

Training program	No. of trainees	Cooparating institutions
Category of training:		
Medical resident (noncareer)	15	
Dental assistant trainee	6	Chabot College; Hayward, Calif.
Audiology and speech pathology student (master's).	9	San Jose State College; San Jose, Calif.
Social work student (master's)	2	University of California; Berkeley, Calif.
Physical therapist student	9	University of California Medical Center; San Francisco, Calif.; Boston University—Boston, Mass.
Basic nursing student	1	Chabot College—Hayward. Calif.
Practical nurse student	12	Livermore Board of Education.
Professional nursing student	9	

LIVERMORE, CALIF.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Dental assistant trainee						16
Practical nurse student	$11,500		$11,500			15
Social work student	17,980	5,980	12,000			2
Hospital librarian student	7,649	7,649				1
Audiology and speech training	3,335	3,335				1
Total	40,464	16,964	23,500			35
NEW PROGRAMS						
Dental hygienist training	46,000			$12,000	$34,000	15
Occupational therapy student	25,213	13,734	11,479			2
X-ray technician training	8,982		8,982			2
Total	98,195	13,734	20,461	12,000	34,000	19
Grand total	259,318	30,698	43,961	12,000	34,000	54

LONG BEACH, CALIF.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	168	
Career psychiatry resident	2	
Career neurology resident	1	
Career P. M. & R. resident	1	
Career radilogy resident	2	
Career pathology resident	3	
Dental resident (noncareer)	3	
Career dental resident	7	
Career dental intern	2	
Medical student 2d 2 school years	121	University of California College of Medicine, Irvine, Calif.
Basic nursing student	249	Long Beach City College, Long Beach, Calif.; California State College, Long Beach, Calif.; St. Vincent's College of Nursing, Los Angeles, Calif.
Practical nurse student	196	Long Beach City College, Long Beach, California.
Psychology student (graduate)	6	University of Southern California, Los Angeles, Calif.; University of California, Los Angeles, Calif.; Catholic University, Washington, D.C.; University of Arizona, Tucson, Ariz.
Vocational rehabilitation counselor student	6	California State College, Los Angeles, Calif.
Social work student (master's)	4	California State College, San Diego, Calif.
Social work student (baccalaureate)	4	California State College, Long Beach, Calif.
Occupational therapist student	10	San Jose State College, San Jose, Calif.; Colorado University, Ft. Collins, Colo.; Boston University, Boston, Mass.; Eastern Michigan University, Ypsilanti, Mich.; University of Wisconsin, Madison, Wis.
Physical therapist student	18	Loma Linda University, Loma Linda, Calif.; California State College, Long Beach, Calif.; Childrens Hospital, Los Angeles, Calif.
Corrective therapist student	9	California State College, Long Beach, Calif.
Dietetic student	15	California State College, Long Beach, Calif.
Medical technologist student	12	California State College, Long Beach, Calif.; California State College, San Bernardino, Calif.; University of California, Riverside, Calif.; Mount St. Mary's College, San Francisco, Calif.
Histologic or histopathology technician trainee	4	
Radiologic technologist trainee	29	Long Beach City College, Long Beach, Calif.; Fullerton Junior College, Fullerton, Calif.
Prosthetic representative trainee	1	
Building management officer trainee	1	
Paramedical services orientation (nursing home employees).	26	Compton Convalescent Hospital, Compton, Calif.; Sunlight Newport Convalescent Hospital, Newport Beach, Calif.; Sunlight Norwalk Convalescent Hospital, Norwalk, Calif.; Leisure Golden Hours Convalescent Hospital, Torrance, Calif.; Woodruff Convalescent Hospital, Bellflower, Calif.; Orange West Convalescent Hospital, Buena Park, Calif.; Huntington Beach Convalescent Hospital, Huntington Beach, Calif.; Sunlite Park Convalescent Hospital, Fullerton, Calif.

LONG BEACH, CALIF.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Dental assistant trainee	$17,200	0	$16,000	------------	$1,200	16
Social work (MSW)	35,800	$19,800	14,000	------------	2,000	6
Occupational therapy trainee	36,150	26,000	9,900	------------	250	8
Physical therapy trainee	10,150	0	9,900	------------	250	6
Corrective therapy trainee	10,150	0	9,900	------------	250	4
Dietetic student	0	0	0	------------	0	4
Medical technology trainee	73,000	19,000	39,000	------------	15,000	4
Medical radiology technologist	40,000	30,000	10,000	------------	0	8
Total	222,450	94,800	108,700	------------	18,950	56
NEW PROGRAMS						
Dental laboratory trainee	23,800	0	22,000	------------	1,800	8
Audiology and speech pathologist (M.S.)	39,000	11,000	14,000	------------	14,000	2
Audiology and speech pathologist (Ph.D.)	40,000	12,000	14,000	------------	14,000	2
Social worker (B.A.)	0	0	0	------------	0	4
Social worker assistant	10,000	0	10,000	------------	0	4
Manual arts therapy trainee	37,750	27,600	9,900	------------	250	6
Occupational therapy assistant trainee	18,900	18,400	0	------------	500	4
Physical therapy assistant trainee	18,500	18,000	0	------------	500	4
Pharmacy intern	9,000	9,000	0	------------	0	1
Pharmacy resident	11,000	11,000	0	------------	0	1
Dietetic affiliate	10,000	0	10,000	------------	0	6
Cytotechnical trainee	21,000	7,000	10,000	------------	4,000	2
Medical technologist trainee	19,000	5,000	10,000	------------	4,000	4
Pathology assistant trainee	21,000	7,000	10,000	------------	4,000	2
Autopsy assistant trainee	19,000	5,000	10,000	------------	4,000	2
Hospital library trainee	26,000	15,000	10,000	------------	1,000	2
Hospital library student	15,000	15,000	0	------------	0	2
Radiation therapy trainee	4,000	4,000	0	------------	0	2
Orthodontic/prosthetic trainee	6,000	6,000	0	------------	0	1
Orthodontic/prosthetic aid	6,000	6,000	0	------------	0	1
Prosthetic representative trainee	7,000	7,000	0	------------	0	1
Medical receiving library trainee	6,600	6,600	0	------------	0	1
Medical receiving library technical trainee	6,000	6,000	0	------------	0	1
Inhalation therapy trainee	13,000	5,000	8,000	------------	0	2
Cardiopulmonary technician	2,500	2,500	0	------------	0	1
Monitoring technician	72,500	60,000	12,000	------------	500	10
Operating room technician	72,500	60,000	12,000	------------	500	10
P.M. & R. coordinator	10,000	10,000	0	------------	0	1
Hospital administration resident	12,000	12,000	0	------------	0	1
Graduate engineer trainee	8,000	8,000	0	------------	0	1
Personnel management trainee	8,000	8,000	0	------------	0	1
Accountant trainee	8,000	8,000	0	------------	0	1
Building management trainee	8,000	8,000	0	------------	0	1
Management analyst trainee	10,000	10,000	0	------------	0	1
Supply management trainee	8,000	8,000	0	------------	0	1
Medical administrative assistant trainee	8,000	8,000	0	------------	0	1
Volunteer services office trainee	8,000	8,000	0	------------	0	1
Library technician	15,000	15,000	0	------------	0	2
Emergency room technician	30,000	30,000	0	------------	0	5
Psychiatry technical trainee	62,500	50,000	12,000	------------	500	10
Total	730,550	507,100	173,900	------------	49,550	113
Grand total	953,000	601,900	282,600	------------	68,500	169

LOS ANGELES, CALIF.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	258	
Medical intern	36	
Career psychiatry resident	5	
Career P.M. & R. resident	6	
Career radiology resident	3	
Career anesthesiology resident	2	
Career pathology resident	3	
Dental resident (noncareer)	3	
Dental intern (noncareer)	7	
Career dental resident	4	
Career dental intern	2	
Medical student, 2d 2 school years	72	University of California at Los Angeles School of Medicine, Los Angeles, Calif.
Dental assistant trainee	12	Los Angeles City College, Los Angeles, Calif.
Dental laboratory technician trainee	36	Do.
Basic nursing student	580	El Camino College, Torrance, Calif.; Santa Monica College, Santa Monica, Calif.; Los Angeles Southwest College, Los Angeles, Calif.; University of California, Los Angeles, Calif.; Los Angeles City College Los Angeles, Calif.; Queen of Angels Hospital, Los Angeles, Calif.; California State College, Los Angeles, Calif.; East Los Angeles College, Los Angeles, Calif.; Hollywood Presbyterian Hospital, Los Angeles, Calif.
Practical nurse student	19	Santa Monica College, Santa Monica, Calif
Audiology and speech pathology student (master's).	5	Valley State College, San Fernando, Northridge, Calif.; California State College, Los Angeles, Calif.; University of Southern California, Los Angeles, Calif.
Psychology student (graduate)	13	University of California, Los Angeles, Calif.; University of Southern California, Los Angeles, Calif.
Vocational rehabilitation counselor student	19	California State College, Los Angeles, Calif.
Social work student (master's)	6	University of California, Los Angeles, Calif.
Occupational therapist student	21	San Jose State College, San Jose, Calif.; University of New Hampshire, Durham, N.H.; Richmond Professional Institute, Richmond, Va.; Eastern Michigan University, Ypsilanti, Mich.; University of Puget Sound, Tacoma, Wash.; University of Kansas, Lawrence, Kans.; Loma Linda University, Loma Linda, Calif.; Los Angeles City College, Los Angeles, Calif.
Physical therapist student	35	University of Southern Calif., Los Angeles, Calif.; Loma Linda University, Loma Linda, Calif.; Children's Hospital of Los Angeles, Los Angeles, Calif.; San Fernando Valley State College, Northridge, Calif.; University of California, Los Angeles, Calif.
Recreation specialist student	3	University of Kansas, Lawrence, Kans.; Alverno College, Milwaukee, Wis.
Occupational therapy assistant trainee	2	Los Angeles City College, Los Angeles, Calif.
Pharmacy resident	2	University of Southern California, Los Angeles, Calif.
Dietetic intern	29	San Diego State College, San Diego, Calif.; University of California, Santa Barbara, Calif.; University of Houston, Houston, Tex.; Fresno State College, Freson, Calif.; University of Nebraska, Lincoln, Nebr.; Case Western Reserve, Cleveland, Ohio; Duchesne College, Omaha, Nebr.; University of Arizona, Tucson, Ariz.; Iowa State University, Ames, Iowa; Southeastern Louisiana, Hammond, La.; Utah State University, Logan, Utah; University of Illinois, Urbana, Ill., California State Polytechnic, San Luis Obispo, Calif.; University of Connecticut, Storrs, Conn.; California State College; Los Angeles, Calif.; Douglass College, New Brunswick, N.J.; Arizona State University, Tempe, Ariz.; California State Polytechnic, Pomona, Calif.; Mount Mary College, Milwaukee, Wis.; University of California, Davis, Calif.; Colorado State University, Fort Collins, Colo.; University of Nebraska, Omaha, Nebr.; University of California, Los Angeles, Calif.
Medical technologist student	6	
Hospital librarian work-study trainee	1	University of California, Los Angeles, Calif.
Radiologic technologist trainee	34	
Medical student anesthesiology trainee	3	University of California at Los Angeles School of Medicine, Los Angeles, Calif.; Jefferson Medical College, Philadelphia, Pa.; University of Texas Southwestern Medical School, Dallas, Tex.
Research and Education trainee	4	University of California at Los Angeles School of Medicine, Los Angeles, Calif.
Accountant trainee	3	
Management analyst trainee	2	
Director, voluntary service trainee	1	
Animal Facilities research supervisor	6	
Nuclear medicine physician trainee	2	
Radiopharmacy student	2	University of Southern California, Los Angeles, Calif.
Animal facilities research supervisor	6	

LOS ANGELES, CALIF.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Dental assistant trainee	$7,800	$7,200			$600	3
Dental laboratory technician trainee	11,010		$10,210		800	10
Audiology and speech pathology student (in master's degree training)	22,130	21,630		$500		2
Occupational therapist student (in baccalaureate or higher training)	22,881	13,000	9,881			3
Pharmacy resident	65,850	62,250	2,808			4
Medical technologist student (in program approved by AMA Council on Medical Education)	116,612	89,622	11,855	1,850	13,185	6
Hospital librarian work-study trainee (as described in M-3, pt. II, par. 5.13b)	19,644	19,644				2
Radiologic technologist trainee—also known as medical radiology technician, medical radiological technician, X-ray technician, etc. (in program approved by AMA Council on Medical Education)	152,056	143,100	8,956			18
Orthotist-prosthetist trainee	58,740	32,740	13,000	12,000	1,000	4
Total	475,831	389,186	56,710	14,350	15,585	52
NEW PROGRAMS						
Social work student (in master's degree training)		6,638	14,192	500		2
Histologic or histopathology technician trainee (supervised laboratory training, acceptable for trainee to be examined for certification as histologic technician)		11,706				2
X-ray technician trainee (in other than program approved by AMA Council on Medical Education)		14,400	7,294		1,000	8
Radiologist's assistant trainee		29,088				4
Total	84,818	61,832	21,486	500	1,000	16
Grand total	560,649	451,018	78,196	14,850	16,585	68

LOS ANGELES, CALIF. (BRENTWOOD)

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Psychology student	$22,640	$8,640	$17,000			12
Vocational rehabilitation counselor	77,000		77,000			12
Total	102,640	8,640	94,000			24
NEW PROGRAMS						
Biomedical instructor technician	25,400	10,400	15,000			4
Grand total	128,040	19,040	109,000			28

LOS ANGELES, CALIF.[1]

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Audiology and speech pathology student (doctoral).	4	University of Southern Calif., University Park, Los Angeles, Calif.
Audiology and speech pathology student (master's).	3	California State College at Los Angeles, Los Angeles, Calif.
Psychology student (graduate)	4	University of California at Los Angeles, Los Angeles, Calif.
Social work student (master's)	8	San Diego State College Graduate School of Social Work, San Diego, Calif.; University of Southern California Graduate School of Social Work, Los Angeles, Calif.; School of Social Welfare, University of California at Los Angeles, Los Angeles, Calif.
Occupational therapist student	5	Boston University Sargents College, Boston, Mass.; San Jose State College, San Jose, Calif.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
NEW PROGRAMS						
Dental assistant trainee	$12,000	$6,000	$5,000	None	$1,000	20
Dental laboratory technician trainee	15,800	9,000	5,000	$1,000	800	22
Audio and speech path student doctoral post	21,611	6,000	15,611	None	None	1
Audio and speech path student masters	9,395	7,210	None	None	2,185	2
Social work student masters program	60,707	22,000	15,611	7,600	15,496	10
Pharmacy assistant trainee	16,972	10,424	6.548	None	None	2
Prosthetic repair trainee	6,748	6,548	None	None	200	1
Grand total	143,233	67,182	47,770	8,600	19,681	58

MARTINEZ, CALIF.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	44	
Medical intern	30	
Career pathology resident	2	
Dental intern (noncareer)	1	
Career dental intern	1	
Dental assistant trainee	2	Diablo Valley College, Pleasant Hill, Calif.
Dental hygienist trainee	12	Diablo Valley College, Pleasant Hill, Calif.
Basic nursing student	165	Contra Costa College, San Pablo, Calif.; Kaiser Foundation Hospital, Oakland, Calif.
Practical nurse student	51	Contra Costa College, San Pablo, Calif.
Psychology student (graduate)	1	University of California, Berkeley, Calif.
Social work student (master's)	2	Sacramento State College, Sacramento, Calif.
Occupational therapist student	4	San Jose State College, San Jose, Calif.
Physical therapist student	8	University of California Medical Center, San Francisco, Calif.
Chaplain resident	5	Graduate Theological Union, Berkeley, Calif.

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[1] Outpatient Clinic

MARTINEZ, CALIF.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Dental assistant trainee	0	0	0	0	0	1
Total	0	0	0	0	0	1
NEW PROGRAM						
Speech pathology	$10,420	$10,420	0	0	0	2
Graduate engineer trainee	11,458	10,528	0	0	$930	1
Accounting trainee	10,873	9,988	0	0	885	1
Building management trainee	8,837	8,098	0	0	739	1
Supply management trainee	8,837	8,098	0	0	739	1
Total	50,425	47,132			3,293	6

PALO ALTO, CALIF.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	129	
Medical intern	21	
Career psychiatry resident	1	
Career P.M. & R. resident	4	
Dental intern (noncareer)	2	
Medical student, 1st 2 school years	36	Stanford University School of Medicine, Stanford, Calif.
Medical student, 2d 2 school years	105	Do.
Basic nursing student	257	University of California School of Nursing, San Francisco, Calif.; Stanford University School of Nursing, Stanford, Calif; San Jose City College, San Jose, Calif; DeAnza College, Cupertino, Calif; College of San Mateo, San Mateo, Calif; St. Luke's Hosiptal School of Nursing, San Francisco, Calif.
Graduate nursing student	3	University of California School of Nursing, San Francisco, Calif.
Audiology and speech pathology student (master's).	2	San Jose State College, San Jose, Calif.
Psychology student (graduate)	34	University of Nevada, Reno, Nev.; University of Oregon, Eugene, Oreg.; University of Arizona, Tucson, Ariz.; University of California, Berkley, Calif.; University of Connecticut, Storrs, Conn.; University of South Dakota, Vermillion, S. Dak.; University of Nebraska, Lincoln, Nebr.; University of Massachusetts, Amherst, Mass.; University of Tennessee, Knoxville, Tenn.; Washington State University, Pullman, Wash.; University of Minnesota, Minneapolis, Minn.; Texas Technological University, Lubbock, Tex.; Clark University, Worcester, Mass.; Georgia State College, Atlanta, Ga.; Ohio State University, Columbus, Ohio.; Duke University, Durham, N.C., Harvard University, Cambridge, Mass.; Adelphi University, Garden City, N.Y.; Southern Illinois University, Carbondale, Ill.; Stanford University, Stanford, Calif.
Psychology student (postdoctoral)	1	Washington State University, Pullman, Wash.
Social work student (master's)	12	University of California, Berkeley, Calif.; Sacramento State College, Sacramento, Calif.
Occupational therapist student	37	University of Puget Sound, Tacoma, Wash.; San Jose State College, San Jose, Calif.; University of Washington, Seattle, Wash.; Virginia Commonwealth University, Richmond, Va.; Colorado StateUniversity, Fort Collins, Colo.; College of St. Catherine, St. Paul, Minn.; University of Kansas, Lawrence, Kansas; University of Minnesota, Minneapolis, Minn.; Western Michigan University, Kalamazoo, Mich.; Mount Mary College, Milwaukee, Wis.; Boston University, Boston, Mass.
Corrective therapist student	3	San Jose State College, San Jose, Calif.
Recreation specialist student	1	Do.
Blind rehabilitation student	15	California State College, Los Angeles, Calif.; Western Michigan University, Kalamazoo, Mich.
Pharmacy student	4	Howard University, Washington, D.C.; University of Utah, Salt Lake City, Utah; Creighton University, Omaha, Nebr.; Washington State University, Pullman, Wash.
Medical record librarian trainee	1	USPH Hospital, Baltimore, Md.
Research and education trainee	1	Stanford University, Stanford, Calif.
Chief nurse trainee	1	

PALO ALTO, CALIF.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Chief of staff trainee	1	
Management analyst trainee	1	San Jose State College, San Jose, Calif.
Supply management trainee	2	
Assistant hospital director trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Basic nursing student	0	0	0	0	0	0
Graduate nursing student	0	0	0	0	0	15
Audiology and speech pathology student	89,665	0	14,665	75,000	0	1
Do	14,253	0	13,096	1,157	0	1
Do	16,125	16,125	0	0	0	5
Audiology and speech pathology	5,000	0	0	0	5,000	0
Psychology (postbaccalaureate)	610,060	390,000	170,060	50,000	0	65
Psychology (postdoctoral)	159,495	92,250	59,745	7,600	0	10
Vocational rehabilitation counselor student	22,280	8,090	14,190	0	0	1
Occupational therapist student	18,000	7,200	10,800	0	0	4
Do	0	0	0	0	0	2
Manual arts therapist student	9,800	0	9,800	0	0	3
Corrective therapist student	0	0	0	0	0	2
Recreation specialist student	9,800	0	9,800	0	0	2
Pharmacy intern	44,780	44,780	0	0	0	5
Electrocardiograph technician trainee	15,500	11,000	4,500	0	0	2
P.M. & R. coordinator trainee	10,800	10,800	0	0	0	1
Chief nurse trainee	0	0	0	0	0	0
Supply management trainee	8,098	8,098	0	0	0	1
Heart pump technician trainee	10,000	8,000	1,000	1,000	0	1
Medical student radiology clerkship	30,000	0	10,000	0	20,000	10
Secretary, audiology and speech pathology	7,294	0	0	0	7,294	1
Total	1,080,950	596,343	317,656	134,757	32,294	132
NEW PROGRAMS						
Practical nurse student	0	0	0	0	0	30
Nursing assistant trainee (public service career program)	89,250	35,484	51,571	0	2,195	15
Nursing intern	0	0	0	0	0	0
Occupational therapy assistant	9.800	0	9,800	0	0	3
Physical therapy assistant	9,800	0	9,800	0	0	3
Manual arts therapy assistant	9,800	0	9,800	0	0	3
P. M. & R, assistant, general	0	0	0	0	0	2
Pharmacy student in any school year	13,096	13,096	0	0	0	2
Pharmacy assistant trainee	20,848	20,848	0	0	0	4
Dietetic student	18,600	6,600	12,000	0	0	1
Food service worker trainee	136,800	124,800	12,000	0	0	20
Medical technician trainee	35,346	18,964	11,382	2,500	2,500	3
X-ray technician trainee	106,236	3,600	49,336	0	53,300	6
X-ray film processor trainee	0	0	0	0	0	0
Radiologist's assistant trainee	37,742	35,632	2,110	0	0	2
Inhalation therapy technician trainee	27,000	15,000	12,000	0	0	2
Physician's assistant trainee	38,100	28,100	10,000	0	0	4
Hemodialysis technician trainee	10,800	10,800	0	0	0	1
Cardiopulmonary technician trainee	18,000	12,000	6,000	0	0	2
Surgery technician trainee	15,500	12,000	3,000	500	0	2
Operating room technician trainee	15,500	12,000	3,000	500	0	2
Orthopedic technician trainee	2,000	0	1,500	500	0	2
Engineer officer trainee	21,500	21,500	0	0	0	2
Accountant trainee	13,007	8,746	3,536	0	725	1
Building management officer trainee	8,746	8,746	0	0	0	1
Laundry superintendent trainee	10,670	10,670	0	0	0	1
Director, voluntary service trainee	9,853	9,853	0	0	0	1
Mental health associate	99,991	72,220	17,223	0	0	10
Consultant			4,000			
Secretary			6,548			
Psychology aid-technician trainee	63,720	30,000	33,720	0	0	5
Total	841,705	510,659	268,326	4,000	58,720	130
Grand total	1,922,655	1,107,002	585,982	138,757	91,014	262

SAN FERNANDO, CALIF.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Social work student (master's)	2	University of California, Los Angeles, Calif.
Occupational therapist student	3	Colorado State College, Fort Collins, Colo.; Loma Linda University, Loma Linda, Calif.
Food service worker trainee	12	Unified School District, Los Angeles, Calif.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
Expandable programs:						
Social work student	6, 200	6, 200	0	0	0	2
Occupational therapy	3, 000	3, 000	0	0	0	2
Total	9, 200	9, 200	0	0	0	4

SAN FRANCISCO, CALIF.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	211	
Medical intern	12	
Career radiology resident	1	
Dental intern (noncareer)	2	
Career dental intern	1	
Medical student 2d 2 school years	164	University of California School of Medicine, San Francisco, Calif.
Dental assistant trainee	8	City College of San Francisco, San Francisco, Calif.
Dental laboratory technician trainee	4	Do.
Basic nursing student	110	University of California School of Nursing, San Francisco, Calif.; University of San Francisco, San Francisco, Calif.
Graduate nursing student	8	University of California School of Nursing, San Francisco, Calif.
Practical nurse student	64	California College of Medical Affiliates, San Francisco, Calif.
Audiology and speech pathology student (doctoral).	8	San Francisco State College, San Francisco, Calif.; Stanford University, Palo Alto, Calif.; University of California, Santa Barbara, Calif.; University of Florida, Gainesville, Fla., University of Wisconsin, Madison, Wis.
Audiology and speech pathology student (master's).	10	San Francisco State College, San Francisco, Calif.
Psychology student (graduate)	21	George Washington University, Washington, D.C.; University of Montana, Missoula, Mont ; Ohio State University, Columbus, Ohio; University of Connecticut, Storrs, Conn.; University of California, Berkeley, Calif.; University of Minnesota, Minneapolis, Minn.; University of Cincinnati, Cincinnati, Ohio; Adelphi University, Garden City, N.Y.; West Virginia University, Morgantown, W. Va.; University of Tennessee, Knoxville, Tenn.; Duke University, Durham, N.C.; Temple University, Philadelphia, Pa.; University of Missouri, Columbia, Mo.; Wright Institute, Berkeley, Calif.

SAN FRANCISCO, CALIF.—Continued

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Psychology student (postdoctoral)	1	University of California, Berkeley, Calif.
Psychology student (baccalaureate)	10	San Francisco Theological Institute, San Anselmo, Calif.; San Francisco State College, San Francisco, Calif.
Social work student (master's)	8	University of California, Berkeley, Calif.; Sacramento, State College, Sacramento, Calif.
Social work student (baccalaureate)	2	University of San Francisco, San Francisco, Calif.
Physical therapist student	2	University of California, San Francisco, Calif.
Pharmacy resident	5	Do.
Pharmacy assistant trainee	19	University of California; San Francisco Unified School District, San Francisco, Calif
Dietetic intern affiliate	2	University of California, Berkeley, Calif.
Cytotechnologist student	2	University of California, San Francisco, Calif.
Histologic or histopathology technician trainee	4	St. Mary's Hospital, San Francisco, Calif.
Podiatry student	44	College of Podiatry, San Francisco, Calif.
Electrocardiograph technician trainee	1	
Operating room technician trainee	20	California College of Medical Affiliates, San Francisco, Calif.
Research and education trainee	2	University of California School of Medicine, San Francisco, Calif.
Personnel management specialist trainee	1	
Podiatry intern	1	College of Podiatry, San Francisco, Calif.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Dental assistant trainee	$8,500		$8,000		$500	8
Dental laboratory technician trainee	21,500	$2,500	8,000	$10,000	1,000	2
Basic nursing student	6,700		6,000		700	10
Graduate nursing student	13,200		10,700		2,500	10
Audiology and speech pathology student	14,250	10,400			3,850	2
Do	46,450	16,400	17,700		12,350	4
Social work student	29,500	7,000	15,000	1,500	6,000	2
Pharmacy resident	7,000	7,000				2
Pharmacy assistant trainee	4,500	4,000			500	2
Dietetic intern affiliate	14,425	825	11,900	1,500	200	3
Dietetic student	2,880	2,880				1
Psychology assistant	41,656	26,060	13,096	2,000	500	5
Total	210,561	77,065	90,396	15,000	28,100	51
NEW PROGRAMS						
Nursing resident	69,100	30,000	10,700	20,000	8,400	5
Pharmacy intern	20,000	20,000				2
Pharmacy student in any school year	13,000		13,000			25
Extracorporeal perfusion (pump) technician trainee	9,600		9,600			1
Opthalmology technician trainee	9,600		9,600			1
Chief of staff trainee	22,500	20,000		1,000	1,500	1
Hospital administration resident	10,900	10,000		500	400	1
Graduate engineer trainee	9,800	9,000		500	300	1
Building management officer trainee	8,050	7,300		500	250	1
Laundry superintendent trainee	8,700	8,500			200	1
Management analyst trainee	9,800	9,500			300	1
Supply management trainee	8,550	7,800		500	250	1
Medical administrative trainee	8,550	7,800		500	250	1
Assistant hospital director trainee	21,500	19,000		1,500	1,000	1
Dental assistants (oral surgery)	82,400	14,400	8,000	30,000	30,000	4
Physician assistants	36,000	28,500		4,500	3,000	3
Total	348,050	191,800	50,900	59,500	45,850	50
Grand total	58,611	268,865	141,296	74,500	73,950	101

19

SEPULVEDA, CALIF.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	36	
Career psychiatry resident	7	
Dental intern (noncareer)	3	
Dental student summer research trainee	1	UCLA, Los Angeles, Calif.
Audiology and speech pathology student (master's).	2	San Fernando Valley State College, Northridge, Calif.
Psychology student (graduate)	12	University of Southern California, Los Angeles, Calif.; UCLA, Los Angeles, Calif.; University of Nebraska, Lincoln, Nebr.; University of Arizona, Tucson, Ariz.; University of Oregon, Eugene, Oreg.; University of Utah ,Salt Lake City, Utah.
Psychology student (postdoctoral)	1	UCLA, Los Angeles, Calif.
Psychology student (baccalaureate)	19	San Fernando Valley State College, Northridge, Calif.; University of Southern California, Los Angeles, Calif.
Social work student (master's)	5	UCLA, Los Angeles, Calif.; University of Southern California, Los Angeles, Calif.
Social work student (baccalaureate)	5	San Fernando Valley State College, Northridge, Calif.
Occupational therapist student	9	University of Wisconsin, Madison, Wisc.; University of Washington, Seattle, Wash.; University of Puget Sound, Tacoma, Wash.; University of Ohio, Athens, Ohio; Loma Linda University, Loma Linda, Calif.
Physical therapist student	5	Loma Linda University, Loma Linda, Calif.; Children's Hospital, Los Angeles, Calif.
Basic nursing student	214	California State College, Los Angeles, Calif.; Los Angeles Valley College, Van Nuys, Calif.
Practical nursing student	11	Holy Cross Hospital, Mission Hills, Calif.
Medical record librarian trainee	1	
Supply management trainee	1	
Assistant hospital director trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE						
Nursing assistant trainee	$60,047	$46,200	$12,302		$1,545	40
Audiology and speech pathology student	32,665	12,000	14,665	$5,000	1,000	2
Do	17,560	17,560				4
Social work student	21,475	6,400	11,173		3 902	2
Occupational therapist student	20,087	1,218	10,869	5,000	3,000	6
Physical therapist student	18,869		10,869	5,000	3,000	10
Manual arts therapist student	12,869		10,869		2,000	10
Total	183,572	83,378	70,747	15,000	14,447	94
NEW PROGRAMS						
Social work student	19,218	11,680	5,587		1,951	2
Educational therapist student	11,869		10,869		1,000	6
Corrective therapist student	11,869		10,869		1,000	10
Recreation specialist student	11,869		10,869		1,000	10
Physical therapy assistant trainee	18,869		10,869	5,000	3,000	20
Medical technician trainee	11,138	9,888			1,250	2
Mental health associate trainee	95,153	64,380	17,223	3,000	10,550	10
Total	179,985	85,948	66,286	8,000	19,751	60
Grand total	363,557	169,326	137,033	23,000	34,198	154

DENVER, COLO,

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	201	
Medical intern	34	
Career pathology resident	1	
Medical student 1st school years	35	University of Colorado School of Medicine, Denver, Colo.
Medical student 2d 2 school years	118	Do.
Basic nursing student	71	University of Colorado School of Nursing, Denver, Colo.
Graduate nursing student	5	Do.
Audiology and speech pathology student (doctoral).	16	University of Denver, Denver, Colo., University of Colorado, Boulder, Colo.
Psychology student (graduate)	16	University of Colorado, Boulder, Colo.
Social work student (doctoral)	6	University of Denver, Denver, Colo.
Physical therapy assistant trainee	4	University of Colorado, Denver, Colo.
Pharmacy resident	2	University of Colorado School of Pnarmacy, Boulder, Colo.
Hospital librarian work-study trainee	2	University of Denver, Denver, Colo.
Medical student anesthesiology trainee	5	University of Colorado School of Medicine, Denver, Colo.
Nuclear medicine technologist trainee	1	
Research and education trainee	3	University of Colorado School of Medicine, Denver, Colo.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPENDABLE PROGRAMS						
Audio and speech pathology	$101,000	$36,000	$15,000	$50,000	0	5
Psychology student	141,500	76,500	45,000	20,000	0	16
Social work student	12,500	0	12,500	0	0	5
Librarian work study	21,000	21,000	0	0	0	3
Nuclear medical technician	8,500	8,500	0	0	0	1
Research and education trainee	80,000	80,000	0	0	0	6
Total	364,500	222,000	72,500	70,000	0	36
NEW PROGRAMS						
Recreation specialist	7,200	7,200	0	0	0	1
Dietetic intern affiliate	0	0	0	0	0	4
Dietetic student	2,000	2,000	0	0	0	2
Food service worker	24,000	24,000	0	0	0	4
EEG technician	10,000	10,000	0	0	0	1
Hemodialysis	6,500	6,500	0	0	0	1
Total	49,700	49,700	0	0	0	13
Grand total	414,200	271,700	72,500	70,000	0	49

FORT LYON, COLO.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Psychology student (graduate)	1	University of Minnesota, Minneapolis, Minn.

GRAND JUNCTION, COLO.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	4	
Basic nursing student	42	Mesa College School of Nursing, Grand Junction, Colo.
Practical nursing student	23	Mesa College Vocational School, Grand Junction, Colo.

GRAND JUNCTION, COLO.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
None	0	0	0	0	0	0
NEW PROGRAMS						
Dental intern	$7,227	7,227	0	0	0	1
Social work assistant trainee	5,560	5,560	0	0	0	1
Occupational therapy assistant trainee	6,500	3,250	0	0	0	2
Physical therapy assistant trainee	6,500	3,250	0	0	0	2
Pharmacy intern	8,098	8,098	0	0	0	1
EKG technician trainee	9,242	4,621	0	0	0	2
Total	43,127	32,006	0	0	0	9
Grand total	43,127	32,006	0	0	0	9

NEWINGTON, CONN.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	27	
Medical intern	23	
Dental assistant trainee	4	Manchester Community College, Manchester, Conn.
Basic nursing student	56	University of Connecticut, Storrs, Conn.
Psychology student (graduate)	4	Do University of Massachussetts, Amherst, Mass.
Social work student (master's)	3	University of Connecticut, Storrs, Conn.
Medical administrative trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Dental assistants	$1,000	$1,000	0			10
Basic nursing students	10,000	0	$10,000			50
Psychology students	10,000	10,000	0			5
Social work students	10,000	10,000	0			2
Medical administrative assistant trainee	5,000	5,000	0			1
Total	36,000	26,000	10,000			68
NEW PROGRAMS						
Dental student summer research trainee	2,000	2,000	0			4
Practical nurse student	10,000	0	10,000			25
Social work student (in MS training)	8,000	8,000	0			2
Pharmacy intern	21,000	12,000	3,000	$2,000	$4,000	2
Pharmacy resident	25,000	20,000	3,000	2,000		2
Pharmacy student	2,000	0	2,000			10
Pharmacy assistant trainee	31,000	9,000	4,000	2,000	16,000	5
Medical technician student	10,000	5,000	0		5,000	5
Total	109,000	56,000	22,000	6,000	25,000	55
Grand total	145,000	82,000	32,000	6,000	25,000	123

WEST HAVEN, CONN.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	160	
Medical intern	55	
Career psychiatry resident	2	
Career pathology resident	2	
Dental intern (noncareer)	1	
Medical student, 1st 2 school years	5	Yale University School of Medicine, New Haven, Conn.
Medical student, 2d 2 school years	119	Do.
Dental assistant trainee	21	Eli Whitney Technical School, Hamden, Conn.
Basic nursing student	306	University of Connecticut, Storrs, Conn.; University of Bridgeport, Bridgeport, Conn.; Waterbury Hospital, Waterbury, Conn.; Stamford Hospital, Stamford, Conn.; Middlesex Memorial Hospital, Middletown, Conn.
Psychology student (postdoctoral)	2	University of Rochester, Rochester, N.Y.; University of Washington, Seattle, Wash.
Social work student (master's)	4	University of Connecticut School of Social Work, Hartford, Conn.
Social work student (baccalaureate)	2	Southern Connecticut State College, New Haven, Conn.
Occupational therapist student	3	Boston University, Boston Mass. State University of; New York, Buffalo, N.Y.
Blind rehabilitation student	4	Boston College, Boston, Mass.; Western Michigan University, Kalamazoo, Mich.
Certified laboratory assistant trainee	5	Housatonic Community College, Stratford, Conn.
Hospital librarian work-study trainee	2	Southern Connecticut State College, New Haven, Conn.
Radiologic technologist trainee	20	
Medical student anesthesiology trainee	1	Yale University School of Medicine, New Haven, Conn.
Research and education trainee	2	Do.
Building management officer trainee	1	
Laundry superintendent trainee	1	
Assistant hospital director trainee	1	
Audiology and speech pathology student (master's).	1	Southern Connecticut State College, New Haven, Conn.
Psychology student (graduate)	31	University of Iowa, Iowa City, Iowa.; University of Wisconsin, Madison, Wis.; University of Connecticut Storrs, Conn.; Yale University, New Haven, Conn.; New York, University New York, N.Y.; Teacher's College, Columbia University, New York, N.Y.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Nursing assistant trainee	$28,157		$12,857	$15,000	$300	20
Social work student (master's)	17,905	$6,000	11,905			2
Social work student (bachelor)						2
Blind rehabilitation student	1,360				1,360	6
Physical therapy assistant	28,965	18,484	9,881		600	8
Pharmacy intern	20,000	20,000				3
Certified laboratory assistant trainee	11,000			6,000	5,000	5
Building management office trainee	6,675	6,075			600	1
Laundry superintendant trainee	7,400	6,800			600	1
Psychology aid trainee	12,258	11,258			1,000	2
Total	133,720	68,617	34,643	21,000	9,460	50
NEW PROGRAMS						
Physical therapy student	16,250	5,000	11,000		250	10
Corrective therapy student	17,250	6,000	11,000		250	12
Pathologist assistant trainee	70,390	22,520	12,870	10,000	25,000	4
Inhalation therapy technician trainee	38,500	10,000	12,000	15,000	1,500	4
Surgeons assistant trainee	80,000	5,000	60,000	5,000	10,000	5
Gastroenterologist assstant trainee	25,000	5,000	12,000	3,000	5,000	5
Psychiatrist assistant trainee	70,477	39,524	20,953	5,000	5,000	5
Medical virology trainee	32,000	26,000			6,000	2
Viral and myco plasmal disease technician trainee	130,500	22,500	13,000	75,000	20,000	30
Total	480,367	141,544	152,823	113,000	73,000	77
Grand total	614,087	210,161	187,466	134,000	82,460	127

WASHINGTON, D.C.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	125	
Medical intern	8	
Career psychiatry resident	4	
Career neurology resident	5	
Career P.M. & R. resident	1	
Career radiology resident	5	
Medical student (first 2 school years)	100	George Washington University School of Medicine, Washington, D.C.; Georgetown University School of Medicine, Washington, D.C.; Howard University College of Medicine, Washington, D.C.
Medical student (second 2 school years)	492	Do.
Dental assistant trainee	2	North Virginia Community College, Annandale, Va.
Basic nursing student	97	Catholic University, Washington, D.C.; Georgetown University, Washington, D.C.; Federal City College, Washington, D.C.
Graduate nursing student	15	Catholic University School of *Nursing, Washington*, D.C.
Audiology and speech pathology student (doctoral).	5	University of Maryland, College Park, Md.; Catholic University, Washington, D.C.; Howard University, Washington, D.C.
Audiology and speech pathology student (master's).	14	George Washington University, Washington, D.C.
Psychology student (graduate)	37	University of Maryland, College Park, Md.; Catholic University, Washington, D.C.; George Washington University, Washington, D.C.; University of South Carolina, Columbia, S.C.
Vocational rehabilitation counselor student	1	George Washington University, Washington, D.C.
Social work student (doctoral)	2	Catholic University, Washington, D.C.
Social work student (master's)	11	Catholic University, Washington, D.C.; Howard University, Washington, D.C.
Psychical therapist student	12	University of Pennsylvania, Philadelphia, Pa.; Ohio State University, Columbus, Ohio; University of Puerto Rico, Rio Piedras, P.R.; University of Maryland, College Park, Md.
Pharmacy student	4	Howard University, Washington, D.C.
Medical technologist student	3	Rochester Institute, Rochester, N.Y.
Histologic or histopathology technician trainee	1	
Medical tectnician trainee	8	Montgomery Junior College, Takoma Park, Md.
Hospital librarian work-study trainee	2	University of Maryland, College Park, Md.
Radiologic technologist trainee	9	Georgetown University Hospital, Washington, D.C.
Medical student anesthesiology trainee	1	George Washington University, Washington, D.C.
Cardiopulmonary technician trainee	1	
Ophthalmology technician trianee	2	Georgetown University, Washington, D.C.
Research and education trainee	3	Do.
Personnel management specialist trainee	1	
Accountant trainee	1	
Management analyst trainee	1	
Supply management trainee	1	
Hospital director trainee	2	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Nursing assistant trainee	$30,000	$30,000				6
Pharmacy student	14,000	14,000				2
Medical technician student	40,000	40,000				8
Radiologic technician trainee	30,000	30,000				6
Management analyst trainee	7,200	7,200				1
Total	121,200	121,200				23
NEW PROGRAMS						
Dental laboratory technician trainee	13,000	13,000				2
Restoration technician trainee	6,500	6,500				1
Total	19,500	19,500				3
Grand total	140,700	140,700				26

WILMINGTON, DEL.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	13	
Dental resident (noncareer)	6	
Basic nursing student	69	University of Delaware, Newark, Del.
Psychology student (graduate)	2	Temple University, Philadelphia, Pa.
Social work student (master's)	2	University of Maryland, Baltimore, Md.
Medical technologist student	2	University of Delaware, Newark, Del.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed for					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
Graduate nursing student (in masters degree program)						8
Professional nurse trainee (refresher training)						8
Nursing intern						5
Psychology student (in graduate training)	$21,370	$18,370		$3,000		3
Psychology student (in post-doctorate)	24,367	9,367	$15,000			1
Social work student (in master degree training)	15,000	12,000		3,000		2
Certified lab assistant trainee	13,098	(1)	8,098	5,000		3
Expandable programs total	73,835	39,737	23,098	11,000		30
Occupational therapist student	9,881		9,881			2
Physical therapist student	12,881		9,881	3,000		4
Corrective therapist student	12,881		9,881	3,000		4
Occupational therapy assistant trainee	3,250	3,250				1
Physical therapy assistant trainee	3,250	3,250				1
Corrective therapy assistant trainee	3,250	3,250				1
General P.M. & R. assistant trainee	3,250	3,250				1
Dietetic intern (VA program)	110,360	64,784	42,576	3,000		8
Dietetic intern affiliate	5,000			5,000		12
Dietetic student						1
Food service worker trainee	5,000	5,000				1
New program total	169,003	82,784	72,219	14,000		36
Grand total	242,838	122,521	95,317	25,000		66

BAY PINES, FLA.

I. FISCAL YEAR 1970

Training Program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	1	
Dental assistant trainee	20	Tomlinson Adult Education Center, St. Petersburg, Fla.
Dental hygienist trainee	25	St. Petersburg Junior College, St. Petersburg, Fla.
Basic nursing student	243	Do.
Audiology and speech pathology student (doctoral).	1	University of South Florida, Tampa, Fla.
Audiology and speech pathology student (master's).	3	Do.
Psychology student (graduate)	12	University of Tennessee, Knoxville, Tenn.; Florida State University, Tallahassee, Fla.; University of Georgia, Athens, Ga.; University of Miami, Coral Gables, Fla.
Psychology student (postdoctoral)	4	Florida State University, Tallahassee, Fla.; University of Georgia, Athens, Ga.
Social work student (master's)	5	Florida State University, Tallahassee, Fla.
Building management officer trainee	1	
Professional nursing student	5	Bruce Manor Nursing Home, Bay Pines, Fla.

GAINESVILLE, FLA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	167	
Medical intern	26	
Career psychiatry resident	5	
Career neurology resident	2	
Dental intern (noncareer)	1	
Medical student 2d 2 school years	91	University of Florida College of Medicine, Gainesville, Fla.
Basic nursing student	115	University of Florida College of Nursing, Gainesville, Fla.
Graduate nursing student	4	Do.
Nursing intern	7	University of Florida College of Nursing, Gainesville, Fla.; Santa Fe Junior College, Gainesville, Fla.
Audiology and speech pathology student (doctoral).	5	University of Florida College of Health Related Professions, Gainesville, Fla.
Audiology and speech pathology student (master's).	2	Do.
Audiology and speech pathology student	6	Do.
Psychology student (graduate)	36	Do.
Psychology student (postdoctoral)	1	Do.
Psychology student (baccaluareate)	6	Do.
Vocational rehabilitation counselor student	11	Do.
Social work student (master's)	10	Florida State University, Tallahasee, Fla.; Atlanta University School of Social Work, Atlanta, Ga.
Occupational therapist student	34	University of Florida College of Health Related Professions, Gainesville, Fla.
Physical therapist student	24	Do.
Recreation specialist student	4	University of Florida College of Physical Education and Health, Gainesville, Fla.
Pharmacy resident	1	University of Florida College of Pharmacy, Gainesville, Fla.
Medical technologist student	32	University of Florida College of Health Related Professions, Gainesville, Fla.
Radiologic technologist trainee	16	Santa Fe Junior College Gainesville, Fla.
Nurse-anesthetist trainee	10	University of Florida College of Medicine, Gainesville, Fla.
Electroencephalograph technician trainee	11	
Hospital administration resident	1	George Washington University College of Government and Business Administration, Washington, D.C.
Personnel management specialist trainee	1	
Accountant trainee	1	
Graduate hospital administrator trainee	1	
Assistant hospital director trainee	2	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
NEW PROGRAMS						
Dietetic interns	$20,400	$12,600	$7,800			12
Medical record librarian trainee	8,900	8,900				2
Inhalation therapy technician trainees	60,000	19,500	12,500	$24,000	$4,000	8
Operating room technician trainees	31,100	13,000	13,100			5
Opthalmology technician trainees	57,300	10,800	17,500	24,000	5,000	3
Chief nurse trainee	13,100	13,100				1
Associate chief nurse, education trainee	13,100	13,100				1
Graduate engineer trainee	8,900	8,900				1
Management analyst trainee	10,868	10,868				1
Grand total	223,668	115,768	50,900	48,000	9,000	34

LAKE CITY, FLA.

I. FISCAL YEAR 1970

Training program	No. of trainees	Cooperating institutions
Medical resident (noncareer)	12	
Medical student 2d 2 school years	5	University of Florida College of Medicine, Gainesville Fla.
Basic nursing student	56	Lake City Junior College, Lake City, Fla.

MIAMI, FLA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical student (noncareer)	197	
Medical intern	82	
Career P.M. & R. resident	4	
Career pathology resident	1	
Medical student 1st 2 school years	92	University of Miami School of Medicine, Miami, Fla.
Medical student 2d 2 school years	123	Do.
Dental laboratory technician trainee	1	Lindsey Hopkins Vocational Center, Miami, Fla.
Dental student summer research trainee	1	Meharry Medical College School of Dentistry, Nashville, Tenn.
Audiology and speech pathology student (doctoral).	3	Syracuse University, Syracuse, N.Y.; Boston University, Boston, Mass.; University of Florida, Gainesville, Fla.
Psychology student (graduate)	26	Florida State University, Tallahassee, Fla.; University of Florida, Gainesville, Fla.; University of Miami, Miami, Fla.; University of Georgia, Athens, Ga.; University of Tennessee, Memphis, Tenn.
Social work student (master's)	18	Barry College, Miami, Fla.; Florida State University, Tallahassee, Fla.
Social work student (baccalaureate)	8	Miami-Dade Junior College, Miami, Fla.
Manual arts therapy student	2	University of Miami, Miami, Fla.
Corrective therapist student	2	Do.
Pharmacy intern	2	North Dakota State University, Fargo, N. Dak.
Dietetic student	4	Barry College, Miami, Fla.
Medical technologist student	6	University of Miami, Miami, Fla.; Ball State University, Muncie, Ind.; Lycoming College, Lycoming, Pa.
Research and education trainee	1	University of Miami School of Medicine, Miami, Fla.
Accountant trainee	1	
Basic nursing student	88	Barry College, Miami, Fla.; Miami-Dade Junior College, Miami, Fla.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Dental laboratory technician trainee	$12,000	$10,500			$1,500	2
Audiology and speech pathology student (in doctoral or post-doctoral training)	10,600	10,600				2
Occupational therapist student (in baccaluareate or higher training)	13,941	4,060	9,881			1
Manual arts therapist student (in baccalaureate or higher training)						1
Corrective therapist student (in baccalaureate or higher training)						3
Pharmacy intern	43,100	43,100				5
Dietetic student (in baccalaureate training)	140				140	17
Food service worker trainee (all levels)	620				620	90
Medical technologist student (in program approved by AMA council on medical education)	8,500	5,000			3,500	2
Medical administrative trainee (assistant chief medical administrative division trainee)	8,100	8,100				1

MIAMI, FLA.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
NEW PROGRAMS						
Dental assistant trainee	37,500	37,000			500	8
Physical therapist student (in baccalaureate or higher training)	9,881		9,881			4
Educational therapist student (in baccalaureate or higher training)						4
Recreation specialist student (in baccalaureate or higher training)						4
Pharmacy assistant trainee (all levels below pharmacist)	31,300	31,300				6
Pathologist's assistant trainee	12,000	12,000				1
Autopsy assistant trainee	9,000	9,000				1
Medical record librarian (in other than program approved by AMA Council on Medical Education)	8,100	8,100				1
Medical record technician trainee (in other than program approved by AMA Council on Medical Education	37,600	29,500	8,100			5
Physician's assistant trainee (comparable to Duke Medical School program)	25,000	18,000	7,000			2
Graduate engineer trainee	9,200	9,200				1
Management analyst trainee	10,000	10,000				1
Supply management trainee	6,600	6,600				1
Director voluntary service trainee	9,000	9,000				1
Assistant hospital director trainee	17,000	17,000				1
Biomedical instrumentation technician trainee	14,000	13,500			500	2
Expandable programs, total	97,001	81,360	9,881		5,760	124
New programs, total	236,181	210,200	24,981		1,000	43
Grand total	333,182	291,560	34,862		6,760	167

ATLANTA, GA.

I. FISCAL YEAR 1970

Training program	No. of trainees	Cooperating institutions
Medical residents (noncareer)	114	
Medical intern	21	
Career radiology resident	3	
Dental resident (noncareer)	3	
Medical student 2d 2 school years	109	Emory University School of Medicine, Atlanta, Ga.
Dental intern (noncareer)	1	
Dental student 2d 2 school years	145	Emory University School of Dentistry, Atlanta, Ga.
Basic nursing student	360	De Kalb College, Atlanta, Ga., Medical College of Georgia, Augusta, Ga., Emory University, Atlanta, Ga.
Graduate nursing student	41	Emory University, Atlanta, Ga.
Audiology and speech pathology student (doctoral)	14	Do.
Social work student (master's)	11	University of Georgia, Athens, Ga., Atlanta University, Atlanta, Ga.
Hospital librarian work-study trainee	1	Emory University, Atlanta, Ga.
Prosthetic representative trainee	1	
Medical student anesthesiology trainee	1	Emory University School of Medicine, Atlanta, Ga.
Research and education trainee	1	
Personell management specialist trainee	3	
Accountant trainee	1	
Management analyst trainee	1	

ATLANTA, GA.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Nursing assistant trainees	$23,979	$12,384	$11,495	0	$100	16
Psychology student	305,000	305,000	0	0	0	50
Social worker students	30,345	18,750	11,495	0	100	18
Subtotal	359,324	336,134	22,990	0	200	84
NEW PROGRAMS						
Dental assistant trainees	4,644	4,644	0	0	0	6
Dental hygienist trainees	2,929	2,929	0	0	0	3
Dental laboratory technician trainees	6,459	5,859	0	0	600	6
Professional nurse trainees	11,718	11,718	0	0	0	12
Social worker assistant trainee	14,132	13,932	0	0	200	18
Physical therapy student	450	450	0	0	0	1
General P.M. & R. assistant trainee	774	774	0	0	0	1
Dietetic resident	5,559	5,559	0	0	0	8
Medical technician student	2,524	2,524	0	0	0	6
Radiologic technician trainee	9,532	8,532	----------	----------	1,000	24
EKG technician trainee	9,532	8,532	0	0	1,000	24
Medical secretary	9,600	8,100	0	0	1,500	18
Clerk DMT	9,109	7,609	0	0	1,500	18
Housekeeping aides	27,700	18,697	8,003	----------	1,000	30
Subtotal	114,662	99,859	8,003	0	6,800	175
Grand total	473,986	435,993	30,993	----------	7,000	259

AUGUSTA, GA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	66	
Medical intern	23	
Career psychiatry resident	2	
Dental resident (noncareer)	4	
Medical student first 2 school years	96	Medical College of Georgia, Augusta, Ga.
Medical student second 2 school years	170	Do.
Dental assistant trainee	1	Do.
Dental hygienist trainee	12	Do.
Basic nursing student	121	University Hospital School of Nursing, Augusta, Ga.; Medical College of Georgia School of Nursing, Augusta, Ga.; Augusta College School of Nursing, Augusta, Ga.
Graduate nursing student	3	Medical College of Georgia School of Nursing, Augusta, Ga.
Practical nurse student	54	Augusta Vocational School of Practical Nursing, Augusta, Ga.; Richmond County Board of Education, Augusta, Ga.
Social work student (master's)	4	University of Georgia School of Social Work, Athens, Ga.
Social work student (baccalaureate)	6	Paine College, Augusta, Ga.
Pharmacy intern	1	University of Georgia, Athens, Ga.
Food service worker trainee	5	Augusta Area Technical School, Augusta, Ga.
Radiologic technologist tainee	3	Medical College of Georgia, Augusta, Ga.
Surgery technician trainee	17	Richmond County Board of Education, Augusta, Ga.
Research and education trainee	1	Medical College of Georgia, Augusta, Ga.
Personnel management specialist trainee	2	
Supply management trainee	1	
Professional nursing student	17	Augusta Vocational School, Augusta, Ga.

AUGUSTA, GA.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS (GEN)						
Basic nursing student	0			0	0	62
Graduate nursing student	0			0	0	14
Practical nurse student	0			0	0	30
Pharmacy intern	$20,003	$8,098	$11,905	0	0	1
Radiologic technologist trainee	80,300	24,000	12,000	$25,000	$19,300	20
Surgery technician trainee	0			0	0	20
Total	100,303	32,098	23,905	25,000	19,300	147
NEW PROGRAMS (GEN)						
Professional nurse trainee	15,478		15,478	0	0	24
Nursing asstistant	55,452	55,452		0	0	12
Nursing intern	43,764	43,764		0	0	6
Nursing resident	17,038	17,308		0	0	2
Physical therapy asst. trainee	9,900	9,900	0	0	0	4
Medical technician trainee	12,375	12,375	0	0	0	5
Physician's asst. trainee	12,375	12,375	0	0	0	5
Total	166,382	150,904	15,478	0	0	58
EXPANDABLE PROGRAMS (PSY)						
Basic nursing student	0			0	0	40
Graduate nursing student	0			0	0	5
Practical nurse student	0			0	0	50
Nursing assistant	0			0	0	12
Psychology student	40,260	23,500	16,760	0	0	5
Social work student (masters degree training)	43,112	19,920	14,192	9,000	0	6
Social work student (baccalaureate training					0	12
Food service worker trainee	0			0	0	10
Total	83,372	43,420	30,952	9,000	0	140
NEW PROGRAMS (PSY)						
Professional nurse trainee	12,000		12,000	0	0	24
Nursing intern	8,519	8,519		0	0	1
Nursing resident	8,519	8,519		0	0	1
Dietetic student (in baccalaureate training)	1,940	1,940		0	0	2
Total	30,978	18,978	12,000	0	0	28

DUBLIN, GA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Certified laboratory assistant trainee	29	
Supply management trainee	1	

DUBLIN, GA.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
Dental assistant trainee	$7, 778	$7, 778				2
Dental laboratory technician trainee	3, 889	3, 889				1
Nursing assistant trainee	68, 682	55, 452	$12, 000		$1, 230	12
Social work student (in master's degree training)	6, 640	6, 640				2
Social work student (in baccalaureate training)	5, 980	5, 980				2
Occupational therapy assistant trainee	15, 636	15, 636				3
Physical therapy assistant trainee	15, 636	15, 636				3
Corrective therapy assistant trainee	15, 636	15, 636				3
Food service worker trainee	50, 916	50, 916				12
Autopsy assistant trainee	4, 920	4, 920				2
X-ray film processor trainee	10, 424	10, 424				2
Electrocardiograph technician trainee	10, 424	10, 424				2
Building management officer trainee	7, 776	7, 776				1
Laundry superintendent trainee	7, 728	7, 728				1
Management analyst trainee	11, 112	11, 112				1
Medical administrative trainee (Assistant Chief, Medical Administrative Division trainee)	8, 460	8, 460				1
Assistant hospital director trainee	18, 288	18, 288				1
Total	269, 925	256, 695	12, 000		1, 230	51

HONOLULU, HAWAII

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Social work student (master's)	2	University of Hawaii, Honolulu, Hawaii.

BOISE, IDAHO

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Dental assistant trainee	11	Boise State College, Boise, Idaho.
Basic nursing student	128	Do.
Practical nurse student	19	Do.
Social work student (baccalaureate)	9	Do. Northwest Nazarene College, Nampa, Idaho.
Medical record technician trainee	4	Boise State College, Boise, Idaho.
Professional nurse trainee	19	Do.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
NEW PROGRAMS						
Personnel management specialist training	$7, 071	$7, 071				1
Building management officer training	7, 071	7, 071				1
Laundry superintendent trainee	8, 478	8, 478				1
Supply management trainee	7, 071	7, 071				1
Medical administrative trainee	7, 071	7, 071				1
Total	36, 762	36, 762				5
Grand total	36, 762	36, 762				5

CHICAGO, ILL. (RES.)

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutious
Medical resident (noncareer)	136	
Medical intern	30	
Dental resident (noncareer)	1	
Dental intern (noncareer)	1	
Medical student, 1st 2 school years	69	Northwestern Medical School, Chicago, Ill.
Medical student, 2d 2 school years	120	Do.
Dental student summer research trainee	1	Northwestern University Dental School, Chicago, Ill.
Basic nursing student	43	De Paul University School of Nursing, Chicago, Ill.
Graduate nursing student	15	Do.
Psychology student (graduate)	5	Northwestern University Graduate School, Chicago, Ill. Loyola University Graduate School, Chicago, Ill. University of Chicago Graduate School, Chicago, Ill.
Social work student (master's)	4	Loyola University School of Social Work, Chicago, Ill. University of Illinois, Chicago, Ill. Jane Addams School of Social Work, Chicago, Ill.
Physical therapist student	13	Northwestern University, Chicago, Ill.
Medical technologist student	4	Roosevelt University, Chicago, Ill.
Inhalation therapy technician trainee	23	Loop College, Chicago, Ill.
Graduate engineer trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Social work service (graduate school field work)	$22,600	$9,000	$13,000	None	$600	3
Nursing assistant	272,164	178,164	84,000	$10,000	None	48
Laboratory technician	82,165	13,200	13,000	31,000	24,965	6
Total	376,929	200,364	110,000	41,000	25,565	57
NEW PROGRAMS						
Dietetic technician	8,900	None	8,900	None	None	10
Radiology technician	12,000	None	10,000	None	2,000	5
Total	20,900	None	18,900	None	2,000	15
Grand total	397,829	200,364	128,900	41,000	27,565	72

CHICAGO, ILL. (WEST SIDE)

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	92	
Medical intern	28	
Dental resident (noncareer)	4	
Dental intern (noncareer)	1	
Dental assistant trainee	24	University of Illinois, Chicago, Ill. Martin Luther King Health Center, Chicago, Ill.
Dental Hygienist trainee	28	Northwestern University, Chicago, Ill.
Basic nursing student	137	University of Illinois, Chicago, Ill.
Practical nurse student	144	Board of Education, Chicago, Ill. St. Frances X. Cabrini School of Practical Nursing, Chicago, Ill.
Audiology and speech pathology student (master's).	4	De Paul University, Chicago, Ill. Northern Illinois University, De Kalb, Ill.
Psychology student (graduate)	15	University of Illinois, Chicago, Ill. Loyola University, Chicago, Ill. Northwestern University, Chicago, Ill.
Social work student (master's)	14	University of Illinois, Chicago, Ill. University of Chicago, Chicago, Ill. Loyola University, Chicago, Ill.
Certified laboratory assistant	18	Board of Education, Chicago, Ill.
Research and education trainee	2	University of Illinois College of Medicine, Chicago, Ill.
Supply management trainee	2	
Medical student, 1st 2 school years	18	Do.
Medical student, 2d 2 school years	147	Do.

CHICAGO, ILL. (W.S.)

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Audiology and speech pathology	$14,870	$11,670		$3,000	$200	3
Social work student	45,300	23,800	$15,000	6,000	500	7
Supply management trainee	13,000	12,000		1,000		2
Respiratory care	20,005		11,905	6,000	2,100	22
Drug abuse	1,100		500		600	500
Intensive care	7,300		6,000		1,300	142
Inservice orientation	7,500		6,000		1,500	150
Total	109,075	47,470	39,405	16,000	6,200	826
NEW PROGRAMS						
Rehabilitation nursing	21,692		14,192	5,000	2,500	150
Grand total	130,767	47,470	53,597	21,000	8,700	976

DANVILLE, ILL.

I. FISCAL YEAR 1970

Training Program	Number of trainees	Cooperating institutions
Basic nursing student	22	Indiana State University, Terre Haute, Ind.
Psychology student (graduate)	19	University of Illinois, Urbana, Ill. Purdue University, West Lafayette, Ind.
Social work student (master's)	6	University of Illinois, Urbana, Ill.
Manual arts therapist student	2	Eastern Illinois University, Charleston, Ill. Southern Illinois University, Carbondale, Ill.
Laundry superintendent trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Basic nursing student		0	0		0	22
Social work student	$39,857	$26,364	$13,493		0	8
Manual arts therapists		0	0		0	2
Occupational therapist student		0	0		0	4
Physical therapist student		0	0		0	4
Corrective therapist student		0	0		0	4
Recreation speciality student		0	0		0	2
Total	39,857	26,364	13,493		0	48

Note: New programs.—The University of Illinois plans a medical school on the Champaign-Urbana Ill., campus, hopefully to begin in the fall of 1971. Part of the 1-year curriculum would be on campus; part off. We have had discussions with the dean regarding an affiliation; there is a need for our facilities; the status of negotiations is in the draft stage.

DOWNEY, ILL

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	2	
Career psychiatry resident	4	
Dental assistant trainee	29	Kenosha Technical Institute, Kenosha, Wis.; Lake County College, Grayslake, Ill.
Dental hygienist trainee	24	Wm. Rainey Harper College, Palatine, Ill.
Dental laboratory technician trainee	2	U.S. Navy Training Center, Great Lakes, Ill.
Basic nursing student	143	Loyola University School of Nursing, Chicago, Ill.; Wm Rainey Harper College, Palatine, Ill.; Passavan Hospital School of Nursing, Chicago, Ill.; Luthera General Hospital, Chicago, Ill.; Augustana Hospital Chicago, Ill.
Practical nurse student	65	Kenosha Technical Institute, Kenosha, Wis.
Psychology student (graduate)	13	Loyola University, Chicago, Ill.; University of Chicago, Chicago, Ill.; Temple University, Philadelphia, Pa.
Social work student (master's)	2	Jane Addams School of Social Work, University of Illinois, Chicago Circle Campus, Chicago, Ill.
Recreation specialist student	1	Kansas University, Lawrence, Kans.
Personnel management specialist trainee	1	
Supply management trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Dental assistant	0	0	0	0	0	10
Dental hygienist	0	0	0	0	0	12
Dental Laboratory Technician	0	0	0	0	0	4
Basic nursing	0	0	0	0	0	50
Practical nurse	0	0	0	0	0	30
Social work study	0	0	0	0	0	6
Recreation specialist	0	0	0	0	0	6
Dietetic intern	0	0	0	0	0	6
Personnel management specialist	0	0	0	0	0	2
Supply management specialist	0	0	0	0	0	2
Total	0	0	0	0	0	128
New programs	0	0	0	0	0	0
Grand total	0	0	0	0	0	128

HINES, ILL.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	169	
Medical intern	1	
Career psychiatry resident	1	
Career radiology resident	2	
Career anesthesiology resident	4	
Dental resident (noncareer)	6	
Dental intern (noncareer)	1	
Career dental resident	1	
Medical student, 1st 2 school years	151	Loyola University, Stritch School of Medicine, Maywood, Ill.; University of Illinois College of Medicine, Chicago, Ill.
Medical student, 2d 2 school years	242	Loyola University, Stritch School of Medicine, Maywood, Ill.; University of Illinois College of Medicine, Chicago, Ill.
Dental student, 2d 2 school years	87	Loyola University School of Dentistry, Chicago., Ill.
Basic nursing student	126	St. Bernard's Hospital School of Nursing, Chicago, Ill.; Oak Park Hospital School of Nursing, Oak Park, Ill.; Silver Cross Hospital School of Nursing, Joliet, Ill.; Triton Junior College, River Grove, Ill.

HINES, ILL.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Psychology student (graduate)	15	University of Chicago, Chicago, Ill. Loyola Universty, Chicago, Ill.
Psychology student (baccalaureate)	9	Elmhurst College, Elmhurst, Ill.; Manchester College, North Manchester, Ind.
Social work student (master's)	14	University of Chicago, Chicago, Ill.; Loyola University, Chicago, Ill.; University of Illinois, Chicago, Ill.; George Williams College, Downers Grove, Ill.
Social work student (baccalaureate)	2	Elmhurst College, Elmhurst, Ill.
Occupational therapist student	40	Eastern Michigan University, Ypsilanti, Mich.; Mount Mary College, Milwaukee, Wis.; University of Wisconsin, Madison, Wis.; University of Illinois, Chicago, Ill.; University of Colorado, Fort Collins, Colo.; University of Minnesota, St. Paul, Minn.
Physical therapist student	26	University of Wisconsin, Madison, Wis.; Northwestern University, Chicago, Ill.; Marquette University, Milwaukee, Wis.
Manual arts therapist student	1	Northern Illinois University, De Kalb, Ill.
Corrective therapist student	1	De Paul University, Chicago, Ill.
Recreation specialist student	3	Triton Junior College, River Grove, Ill.
Blind rehabilitation student	17	Western Michigan University, Kalamazoo, Mich.
Pharmacy resident	2	University of Illinois College of Pharmacy, Chicago, Ill.
Dietetic intern	42	
Histologic or histopathology technician trainee	1	
Medical technician trainee	2	
Autopsy assistant trainee	1	
Radiologic technologist trainee	43	Triton Junior College, River Grove, Ill.; Central YMCA, Chicago, Ill.
Veterinary medical resident investigator trainee	10	
Chief of staff trainee	1	
Supply management trainee	1	
Electromyogram physician trainee	3	Schwab Rehabilitation Institute, Chicago, Ill.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructors' salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Psychology student	$20,000	----------	$17,000	----------	$3,000	25
Social work student	44,275	$15,000	26,775	$1,500	1,000	6
Occupational therapy student	65,805	33,500	20,765	----------	11,540	20
Physical therapy student	32,400	20,400	12,000	----------	----------	12
Manual arts therapy student	6,800	6,800	----------	----------	----------	4
Educational therapy student	3,400	3,400	----------	----------	----------	2
Corrective therapy student	6,800	6,800	----------	----------	----------	4
Recreation therapy student	20,500	8,500	12,000	----------	----------	5
Pharmacy resident	28,000	28,000	----------	----------	----------	3
Dietetic intern	35,000	35,000	----------	----------	----------	5
Inhalation therapist	14,000	12,000	----------	----------	2,000	2
EKG technician	7,000	6,000	----------	----------	1,000	1
Hemodialysis technician	14,000	12,000	----------	----------	2,000	2
Nuc. medical technician	62,000	24,000	----------	30,000	8,000	6
Vet. medical resident intern trainee	144,000	120,000	----------	----------	24,000	8
Graduate engineer trainee	8,100	8,100	----------	----------	----------	1
Total	512,080	339,500	88,540	31,500	52,540	106
NEW PROGRAMS						
Speech pathology student	45,500	16,000	16,750	3,000	9,550	2
Histological technician	73,250	60,000	13,000	----------	250	10
X-ray therapy technician	80,000	40,000	25,000	5,000	10,000	20
Medical research library trainee	8,100	8,100	----------	----------	----------	1
Physical assistance trainee	140,000	97,200	35,000	----------	7,800	12
Building managment office trainee	6,000	6,000	----------	----------	----------	1
Medical administration trainee	10,000	10,000	----------	----------	----------	1
Director, volunteer service trainee	16,200	16,200	----------	----------	----------	2
Total	379,050	253,700	89,750	8,000	27,600	49
Grand Total	891,130	593,200	178,290	39,500	80,140	155

MARION, ILL.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
NEW PROGRAMS						
Dietetic student (in baccalaureate training)	$11,706	$11,706	None	None	None	2
Medical administration trainee	8,908	8,908	do	do	do	1
Total	20,614	20,614				3

FORT WAYNE, IND.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Dental assistant trainee	7	Indiana University, Fort Wayne campus, Fort Wayne Ind.
Dental hygienist trainee	33	Do.
Basic nursing student	86	Purdue University, Fort Wayne campus, Fort Wayne, Ind.
Social work student (baccalaureate)	1	Atlanta University, Atlanta, Ga.
Dietetic student	2	Manchester College, North Manchester, Ind.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Dental assistant	0	0	0	0	0	4
Dental hygienist	0	0	0	0	0	2
Total	0	0	0	0	0	6
NEW PROGRAMS						
Licensed practical nurse	$65,128	$51,113	$13,015	0	$1,000	10
Laboratory technician	34,002	22,663	10,839	0	500	5
Total	99,130	73,776	23,854	0	1,500	15

INDIANAPOLIS, IND.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	134	
Medical intern	34	
Career psychiatry resident	1	
Career neurology resident	1	
Career anesthesiology resident	2	
Dental resident (noncareer)	6	
Dental intern (noncareer)	1	
Medical student (first 2 school years)	79	Indiana University School of Medicine, Indiananpolis, Ind.
Medical student (second 2 school years)	234	Do.
Basic nursing student	213	Indiana University School of Nursing, Indianapolis, Ind.
Graduate nursing student	3	Do.
Psychology student (graduate)	10	Indiana University, Biolomington, Ind.
Social work student (master's)	8	Atlanta School of Social Work, Atlanta, Ga.; Indiana University, Indianapolis, Ind.
Physical therapist student	3	Indiana University, Indianapolis, Ind.
Pharmacy intern	2	Purdue and Butler Universities, Indianapolis, Ind.
Pharmacy resident	4	Do.
Dietetic intern affiliate	8	Indiana University, Indianapolis, Ind.
Psychology student (graduate)		Purdue University, Lafayette, Ind.
Radiologic technologist trainee	40	Indiana University, Indianapolis, Ind.
Associate cheif nurse, nursing education, trainee	1	

INDIANAPOLIS, IND.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed — Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Nuclear medicine technologist trainee	$12,000	$11,000	None	None	$1,000	2

MARION, IND.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	119	Purdue University, West Lafayette, Ind. Ball State University, Muncie, Ind. Marion College, Indianapolis, Ind. Taylor University, Upland, Ind.
Practical nurse student	59	Marion Com. School of Practical Nursing, Marion, Ind. Kokomo School of Practical Nursing, Kokomo, Ind.
Psychology student (graduate)	8	Purdue University, West Lafayette, Ind.
Psychology student (postdoctoral)	1	Do.
Social work student (master's)	2	Atlanta University, Atlanta, Ga.
Corrective therapy student	2	Taylor University, Upland, Ind.
Dietetic student	2	Indiana State University, Terre Haute, Ind.
Personnel management specialist trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed — Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Nursing assistant trainee	$119,776	$119,776	0	0	0	24
Social work student (master's degree program)	50,082	8,970	$15,327	$500	$25,285	3
Social work student (bachelor's degree program)	24,797	8,970	15,327	500	0	3
Corrective therapist student	10,672	0	9,672	0	1,000	8
Manual arts therapist student	38,672	0	9,672	25,000	4,000	8
Occupational therapist assistant trainee	17,467	7,795	9,672	0	0	0
Physical therapy assistant trainee	17,889	8,217	9,672	0	0	1
Personnel management specialist trainee	9,246	8,746	0	500	0	1
Total	288,601	162,474	69,342	26,500	30,285	48
NEW PROGRAMS						
Dental assistant trainee	8,910	8,910	0	0	0	2
Dental laboratory technician trainee	5,629	5,629	0	0	0	1
Basic nursing student (associate degree)	7,500	0	0	7,500	0	15
Basic nursing student (baccalaureate degree)	7,500	0	0	7,500	0	15
Education therapist student	9,672	0	9,672	0	0	8
Recreation specialist student	13,172	0	9,672	0	3,500	8
Social work assistant trainee	47,846	28,287	0	2,000	17,559	4
Dietetic student	21,206	21,206	0	0	0	3
Food service worker trainee	138,262	127,591	10,671	0	0	40
Medical technician trainee	17,699	17,699	0	0	0	3
Graduate engineer trainee	8,586	8,586	0	0	0	1
Supply management trainee	8,586	8,586	0	0	0	1
Summer students in health career professions [1]	77,945	77,945	0	0	0	0
Total	372,513	304,439	30,015	17,000	21,059	101
Grand total	661,114	466,913	99,357	43,500	51,344	149

DES MOINES, IOWA

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	20	
Dental assistant trainee	30	Area XI Community College, Ankeny, Iowa.
Basic nursing student	36	Broadlawn Polk County Hospital, Des Moines, Iowa.
Practical nurse student	27	Des Moines Practical Nurse School, Des Moines, Iowa.
Psychology student (graduate)	1	University of Iowa, Iowa City, Iowa.
Psychology student (postdoctoral)	1	Iowa State University, Aimes, Iowa.
Social work student (master's)	4	University of Iowa, Iowa City, Iowa.
Occupational therapy assistant trainee	12	Kirkwood Community College, Cedar Rapids, Iowa.
Medical technician trainee	6	Area XI Community College, Ankeny, Iowa.
Nurse-anesthetist trainee	4	Broadlawns Polk County Hospital, Des Moines, Iowa.
Operating room technician trainee	10	Area XI Community College, Ankeny, Iowa.
Building management officer trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAM						
Social work students	$17,910	$17,910	0	0	0	8
Pharmacy student	0	0	0	0	0	10
Total	17,910	17,910	0	0	0	18
NEW PROGRAMS						
Medical administrator trainee	8,092	8,098	0	0	0	1
Grand total	26,008	26,008	0	0	0	19

IOWA CITY, IOWA

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	184	
Medical intern	43	
Dental resident (noncareer)	5	
Dental intern (noncareer)	4	
Career dental intern	1	
Medical student, 1st 2 school years	16	University of Iowa College of Medicine, Iowa City, Iowa.
Medical student, 2d 2 school years	117	Do.
Dental student, 2d 2 school years	58	University of Iowa College of Dentistry, Iowa City, Iowa.
Dental hygienist trainee	7	Do.
Dental laboratory technician trainee	1	Do.
Basic nursing student	211	University of Iowa College of Nursing, Iowa City, Iowa; Kirkwood Community College, Cedar Rapids, Iowa.
Audiology and speech pathology student (master's).	7	University of Iowa, Iowa City, Iowa.
Psychology student (graduate)	5	Do.
Social work student (master's)	2	Do.
Occupational therapist student	5	Do.
Physical therapist student	21	Do.
Pharmacy intern	2	
Pharmacy resident	2	Do.
Pharmacy student	4	Do.
Dietetic resident	1	Do.
Medical technologist student	50	Do.
Hospital librarian work-study trainee	3	Do.
Research and education trainee	3	Do.
Graduate engineer trainee	1	
Accountant trainee	4	Do.

IOWA CITY, IOWA

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDING PROGRAM						
Dental assistant						32
Dental hygienist						20
Audiology and speech pathology students	$43,000	$18,000	$15,000	$2,000	$8,000	3
Medical technician students	5,000	5,000				3
Hospital librarian work study	7,500	7,500				1
Total	55,500	30,500	15,000	2,000	8,000	59
NEW PROGRAMS						
Chief nurse trainee	13,000	13,000				1
Occupational therapy students	5,400	5,400				8
Physical therapy students	15,400	5,400	10,000			8
Corrective therapy students	2,700	2,700				4
Recreation therapy students	2,700	2,700				4
Autopsy assistant trainee	8,500	8,500				1
Clinical microbiology technician	102,000	80,000	16,000		6,000	4
Radiologic technician	2,500	2,500				2
X-ray film processor	5,000	5,000				2
Radiologist assistant	6,200	6,200				1
Inhalation therapy technician trainee	52,000	22,000	30,000			10
Physician's assistant trainee	177,000	27,000	100,000		50,000	10
Director, volunteers trainee	8,500	8,500				1
Hospital administrative resident	24,000	24,000				3
Total	424,900	212,900	156,000		56,000	59
Grand total	480,400	243,400	171,000	2,000	64,000	118

KNOXVILLE, IOWA

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	135	Iowa Methodist Hospital, Des Moines, Iowa. Memorial Hospital at Burlington Burlington, Iowa. Iowa Tech Area XV Community College, Ottumwa, Iowa.
Social work student (master's)	4	School of Social Work University of Iowa, Iowa City, Iowa.
Occupational therapy assistant	4	Kirkwood Community College, Cedar Rapids, Iowa.
Osteopathy student (any school year)	64	College of Osteopathic Medicine and Surgery, Des Moines, Iowa.
General hospital services orientation	4	Knoxville Community High School, Knoxville, Iowa.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Graduate training in social work	$6,000	$6,000	None	None	None	2

TOPEKA, KANS.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	28	
Career psychiatry resident	17	
Medical student second 2 school years	7	Menninger School of Psychiatry, Topeka, Kans.
Basic nursing student	166	Research Hospital-Medical Center, Kansas City, Mo.; Stormont Vail Hospital, Topeka, Kans.; Marymount College, Salina, Kans.
Audiology and speech pathology student (master's).	12	Kansas State University, Manhattan, Kans.
Psychology student (graduate)	20	University of Kansas, Lawrence, Kans.
Social work student (master's)	12	Do.
Social work student (baccalaureate)	14	Washburn University, Topeka, Kans.; University of Kansas, Lawrence, Kans.
Occupational therapist student	11	Indiana University, Indianapolis, Ind.; University of Kansas, Lawrence, Kans.; University of Iowa, Iowa City, Iowa.
Recreation specialist student	3	Washburn University, Topeka, Kans.; University of Kansas, Lawrence, Kans.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

EXPANDABLE PROGRAMS

The following programs could be expanded:
Basic nursing student (in diploma, associate degree, and baccalaureate programs).
Nursing assistant trainee (nursing aid, attendant, orderly, etc., all levels).
Audiology and speech pathology student (in master's degree training).
Audiology and speech pathology student (in baccalaureate training).
Social work student (in master's degree training).
Social work student (in baccalaureate training).
Occupational therapist student (in baccalaureate or higher training).
Recreation specialist student (in baccalaureate or higher training).
Food service worker trainee (all levels).

NEW PROGRAMS

The following new programs could be established:
Graduate nursing student (in master's degree programs).
Practical nurse student—also known as vocational nurse (in training programs, preparing for licensure examination).
Professional nurse trainee (refresher training to prepare for reentry into profession).
Nursing intern.
Social work assistant trainee (holder of bachelor's degree, in training at VA station to assist social worker).
Physical therapist student (in baccalaureate or higher training).
Manual arts therapist student (in baccalaureate or higher training).
Corrective therapist student (in baccalaureate or higher training).
Occupational therapy assistant trainee (all levels below therapist).
Physical therapy assistant trainee (all levels below therapist).
Manual arts therapy assistant trainee (all levels below therapist).
Educational therapy assistant trainee (all levels below therapist).
Corrective therapy assistant trainee (all levels below therapist).
General P.M. & R. assistant trainee (all levels below therapist.)
Pharmacy assistant trainee (all levels below pharmacist).
Medical technician trainee (laboratory training for other than certified status, e.g., laboratory technician, laboratory assistant, laboratory aide, etc., at all levels).
Pathologist's assistant trainee.
Autopsy assistant trainee.
X-ray technician trainee (in other than program approved by AMA Council on Medical Education).
X-ray film processor trainee.
Radiologist's assistant trainee.
Medical record librarian trainee (in other than program approved by AMA Council on Medical Education.)
Medical record technician trainee (in other than program approved by AMA Council on Medical Education).
Inhalation therapy technician trainee—all levels (in other than program approved by AMA Council on Medical Education).
Nurse-anesthetist trainee (in other than program approved by American Association of Nurse Anesthetists).
Electrocardiograph technician trainee.
Electroencephalograph technician trainee.
Surgeon's assistant trainee.
Surgery technician trainee (general).
Orthopedic technician trainee.
Urology technician trainee.
P.M. & R. coordinator trainee.
Chief of staff trainee.
Graduate engineer trainee.
Personnel management specialist trainee.
Accountant trainee.
Building management officer trainee.
Laundry superintendent trainee.
Medical administrative trainee (assistant chief, medical administration division trainee).
Graduate hospital administrator trainee.
Assistant hospital director trainee.
General hospital services orientation (for high school or college students).

Note: Specific costs, salaries, and space needs have not been presented in the required format because these data would vary greatly with the need for trainees and the size of the program established. Since this is a large hospital with a sizable and varied patient population, and a well-qualified, well-trained staff, it is felt the major limiting factor would be the need for and supply of trainees. When these determinations are made, then we could easily indicate needs and compute costs according to the suggested format.

WADSWORTH, KANS.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	10	
Dental resident (noncareer)	4	
Career dental resident	2	
Career dental intern	1	
Basic nursing student	22	Trinity Lutheran Hospital, Kansas City, Mo.
Psychology student (graduate)	15	University of Kansas, Lawrence, Kans.
Social work student (master's)	2	Do.
Physical therapist student	22	Do.
Pharmacy student	6	Do.
Podiatry student	2	Ohio College of Podiatric Medicine, Cleveland, Ohio.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Social work students	$9,960	$9,960				3
Podiatry intern	8,098	8,098				1
Total	18,058	18,058				4
NEW PROGRAMS						
Dental laboratory technicians	187,922	66,922	$40,000	$23,000	$58,000	12
Pharmacy resident	19,762	19,762				2
Public service careers	105,000	105,000				20
Total	312,684	191,684	40,000	23,000	58,000	34
Grand total	330,742	209,742	40,000	23,000	58,000	38

WICHITA, KANS.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	22	
Audiology and speech pathology student (master's).	7	Wichita State University, Wichita, Kans.
Psychology student (graduate)	2	Kansas University, Lawrence, Kans.
Social work student (master's)	2	Do.
Certified laboratory assistant trainee	1	Wichita Vocational School, Wichita, Kans.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
Expandable program	None	None	None	None	None	None
New programs:						
Social work student	$5,980	$5,980	None	None	None	2
Certified laboratory assistant trainee	2,000	2,000	None	None	None	3
X-ray technician trainee	3,640	3,640	None	None	None	2
Personnel management special trainee	8,098	8,098	None	None	None	1
Building management office trainee	8,098	8,098	None	None	None	1
Supply management trainee	8,098	8,098	None	None	None	1
Total	35,914	35,914	None	None	None	10
Grand total	35,914	35,914	None	None	None	10

LEXINGTON, KY.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	44	
Medical intern	32	
Career anesthesiology resident	2	
Dental resident (noncareer)	1	
Medical student 2d 2 school years	139	University of Kentucky College of Medicine, Lexington, Ky.
Medical student 1st 2 school years	85	Do.
Dental hygienist trainee	9	University of Kentucky, Lexington, Ky.
Dental laboratory technician trainee	6	Do.
Basic nursing student	123	Eastern Kentucky State University, Richmond, Ky. Midway Junior College, Midway, Ky. Kentucky State College, Frankfort, Ky.
Psychology student (graduate)	13	University of Kentucky, Lexington, Ky.
Psychology student (baccalaureate)	10	Do.
Social work student (master's)	5	Kent School of Social Work, Louisville, Ky.
Social work student (baccalaureate)	2	Do.
Physical therapist student	9	University of Kentucky, Lexington, Ky.
Corrective therapist student	5	Do. Eastern Kentucky State University, Richmond, Ky.
Recreation specialist student	2	Eastern Kentucky State University, Richmond, Ky. University of Kentucky, Lexington, Ky.
Dietetic intern affiliate	7	Do.
Hospital librarian work-study trainee	3	Do.
Hospital librarian student	9	Do.
Inhalation therapy technician trainee	7	Do.
Chief nurse trainee	2	
Accountant trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Present limitations of space and staff do not permit the expansion or the start of new training programs by September 1971. Major expansion of training programs in the allied health fields will become possible and is being planned when our new General Medical and Surgical Building is completed in July 1972.

LOUISVILLE, KY.

I. FISCAL YEAR 1970

Program name	Number of trainees	Cooperating institutions
Medical resident (noncareer)	85	
Medical intern	12	
Career psychiatry resident	2	
Career pathology resident	1	
Dental resident (noncareer)	6	
Career dental intern	1	
Medical student 1st 2 school years	96	University of Louisville School of Medicine, Louisville, Ky.
Medical student 2d 2 school years	192	Do.
Dental hygienist trainee	19	University of Louisville, Louisville, Ky.
Basic nursing student	92	Spalding College Department of Nursing, Louisville, Ky.; Jefferson Community College, Louisville, Ky.
Audiology and speech pathology student (master's).	6	Indiana University, Bloomington, Ind.
Psychology student (graduate)	2	University of Louisville, Louisville, Ky.
Social work student (master's)	3	Kent School of Social Work, Louisville, Ky.; University of Louisville, Louisville, Ky.
Physical therapist student	10	Indiana University, Bloomington, Ind.
Pharmacy intern	1	University of Kentucky School of Pharmacy, Lexington, Ky.
Medical technologist student	8	University of Louisville, Louisville, Ky.

LOUISVILLE, KY.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Social work student	$13,280	$13,280				4
Occupational therapist	9,000		$9,000			6
Physical therapist	8,200		8,200			4
Nursing assistant						10
Audiology and speech pathologist						4
Pharmacy intern						1
Pharmacy assistant						1
Medical technician						4
Autopsy assistant						1
Hospital librarian						2
Radioisotope technician						2
Orthotist-prosthetist						2
Graduate engineer	8,098	8,098				1
Accountant	8,098	8,098				1
Building management officer	8,098	8,098				1
Medical administrator	8,098	8,098				1
Total	62,872	45,672	17,200			45

ALEXANDRIA, LA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	15	
Manual arts therapist student	1	Northwestern State University, Natchitoches, La.
Recreation specialist student	3	Grambling College, Grambling, La.
Graduate engineer trainee	1	
Accountant trainee	1	

NEW ORLEANS, LA.

I. FISCAL YEAR 1970

Program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	75	
Medical intern	22	
Dental intern (noncareer)	1	
Career dental intern	1	
Medical student 1st 2 school years	81	Tulane University School of Medicine, New Orleans, La.; Louisiana State University School of Medicine, New Orleans, La.
Medical student 2d 2 school years	299	Do.
Dental hygienist trainee	32	Loyola University, New Orleans, La.
Basic nursing student	93	Louisiana State University School of Nursing, New Orleans, La.
Practical nurse student	23	New Orleans Parish School Board, New Orleans, La.
Audiology and speech pathology student (doctoral).	1	Louisiana State University, New Orleans, La.; Tulane University, New Orleans, La.
Audiology and speech pathology student (master's).	4	Louisiana State University, New Orleans, La.; Tulane University, New Orleans, La.
Psychology student (graduate)	24	Louisiana State University, Baton Rouge, La.; University of Georgia, Athens, Ga.; University of Texas, Austin, Tex.; Emory University, Atlanta, Ga ; Florida State University, Tallahassee, Fla.
Social work student (master's)	11	Louisiana State University, Baton Rouge, La.; Tulane University, New Orleans, La.
Medical technologist student	10	Southeastern Louisiana University, Hammond, La.; Dominican College, New Orleans, La.; Xavier University, New Orleans, La.; Louisiana State University, New Orleans, La.

NEW ORLEANS, LA.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Audiology and speech pathology student (in master's degree training)	$34,792	$9,600	$14,192	None	$11,000	2
Social work student (in baccalaureate training)	0	None	None	None	None	10
Pharmacy intern	8,098	8,098	None	None	None	2
Building management officer trainee	8,098	8,098	None	None	None	1
Medical administrative trainee (assistant chief, medical administrative division trainee)	8,956	8,956	None	None	None	1
Total	59,944	34,752	14,192	None	11,000	4

Note: No new programs.

SHREVEPORT, LA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	24	
Basic nursing student	60	Northwestern State College School of Nrusing, Natchitoches, La.; Confederate Memorial Medical Center School of Nursing, Shreveport, La.
Social work student (master's)	1	Louisiana State University, Baton Rouge, La.
Recreation specialist student	8	Grambling College, Grambling, La.
Dietetic student	5	Do.
Electrocardiograph technician trainee	1	American College of Health Careers, Oklahoma City, Okla.
Personnel management specialist trainee	2	
Building management officer trainee	2	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Supply management	$8,098	$8,098	0	0	0	1

TOGUS, MAINE

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	25	Westbrook Junior College, Portland, Maine.
Psychology student (graduate)	5	University of Maine, Orono, Maine.
Corrective therapist student	1	Do.

TOGUS, MAINE

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS (NONE)						
NEW PROGRAMS						
Graduate engineering trainee	$9,000	$9,000	None	None	None	
Personnel management trainee	7,000	7,000	None	None	None	
Building management trainee	7,000	7,000	None	None	None	
Total	23,000	23,000	None	None	None	
Grand total	23,000	23,000	None	None	None	

BALTIMORE, MD.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	79	
Dental intern (noncareer)	1	
Medical student 2d 2 school years	56	University of Maryland School of Medicine, Baltimore, Md.
Basic nursing student	25	University of Maryland, Baltimore, Md.
Psychology student (graduate)	6	Catholic University, Washington, D.C. University of Maryland, Baltimore, Md.
Social work student (master's)	6	Do.
Personnel management specialist trainee	1	
Graduate nursing student	4	Do.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS TOTAL						
Social work student (master's)	$13,260	$9,960	$3,300			3
Nurse anesthetist	9,100	6,600	2,500			1
NEW PROGRAMS TOTAL						
PMS trainee	12,430	8,930	3,500			1
Radiology technician	17,202	4,800	11,902		$500	4
Grand total	51,992	30,290	21,202		500	9

FORT HOWARD, MD.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	9	
Audiology and speech pathology student (master's).	4	University of Maryland, College Park, Md.
Personnel management specialist trainee	1	
Practical nursing student	12	Dundalk Regional Vocational Center, Dundalk, Md.

PERRY POINT, MD.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Career psychiatry resident	2	
Basic nursing student	11	Harford Junior College, Bel Air, Md.
Psychology student (graduate)	1	Catholic University of America, Washington, D.C.
Psychology student (postdoctoral)	1	Florida State University, Tallahassee, Fla.
Social work student (master's)	7	University of Maryland, College Park, Md.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
Social work student	$29,111	$15,940	$13,096	None	$75	5

BEDFORD, MASS.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Dental student 2d 2 school years	2	Harvard School of Dental Medicine, Boston, Mass.
Basic nursing student	157	St. Anselm's Manchester, N.H.; Boston College, Boston, Mass.; Northeastren University, Boston, Mass.; The Memorial Hospital, School of Nursing, Worcester, Mass.
Psychology student (master's)	5	Harvard University, Cambridge, Mass.; Boston University, Boston, Mass.
Psychology student (baccalaureate)	3	Boston University, Boston, Mass.; Brandeis University, Waltham, Mass.
Social work student (master's)	9	Boston College, Boston, Mass.; Boston University, Boston, Mass.; Simmons College, Boston, Mass.
Occupational therapist student	21	Tufts College, Boston, Mass.; Boston University, Boston, Mass.; College of St. Catherine, St. Paul, Minn.; State University of New York at Buffalo, Buffalo, N.Y.; University of New Hampshire, Durham, N.H.
Corrective therapist student	12	Boston University, Boston, Mass.
Dietetic intern affiliate	27	Massachusetts General Hospital, Boston, Mass.
Certified laboratory assistant trainee	5	Northeastern University, Boston, Mass.
Chaplain resident	3	
Chief nurse trainee	1	
Personnel management specialist trainee	1	University of Massachusetts, Amherst, Mass.
Building management officer trainee	2	
Laundry superintendent trainee	1	
Basic nursing student		Somerville Hospital School of Nursing, Somerville, N.Y.
Biochemist	3	Boston University, Boston, Mass.
Dental student (graduate)	1	Do.

BEDFORD, MASS.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Basic nursing student						8
Nursing assistant trainee	$328,260	$277,260	$36,000		$15,000	60
Social work student	50,305	38,400	11,905			12
Occupational therapist student	15,953	6,072	9,881			12
Corrective therapist student	9,881		9,881			12
Dietetic intern affiliate	9,881		9,881			26
Dietetic student (basic training)	5,852	5,853				4
Certified lab assistant trainee						3
Chaplain resident	30,618	30,618				6
Personnel management specialist	7,084	7,084				1
Graduate student biochemistry	18,000	18,000				2
Postdoctoral fellow in biochemistry	24,000	24,000				2
Total	499,799	407,287	77,548		15,000	148
NEW PROGRAMS						
Dental assistant trainee	1,000				1,000	4
Dental hygienist trainee	800				800	2
Dental lab technician trainee	1,200				1,200	2
Graduate nursing student						3
Practical nurse student	114,779	104,240	10,539			20
Professional nurse trainee	83,479	72,940	10,539			10
Social work assistant trainee	82,672	65,480	14,192		3,000	10
Physical therapist student	9,881		9,881			12
Food service worker	70,201	60,320	9,881			10
Nurse anesthetist	9,881	9,881				1
Operating room technician trainee	6,548	6,548				1
Urology technician trainee	6,548	6,548				1
Associate chief nurse trainee (education)	12,000	12,000				1
Accountant trainee	8,098	8,098				1
Supply management trainee	8,098	8,098				1
Medical administration trainee	8,098	8,098				1
Mental health associate	88,151	64,380	17,223	5,000	1,548	10
Rehabilitation counselor alcoholism	74,222	58,530	14,192		1,500	10
Total	585,656	485,161	86,447	5,000	9,048	100
Grand total	1,085,455	892,448	163,995	5,000	24,048	248

BOSTON, MASS.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	189	
Medical intern	30	
Career psychiatry resident	11	
Career P.M. & R. resident	1	
Career anesthesiology resident	1	
Career pathology resident	1	
Dental resident (noncareer)	1	
Dental intern (noncareer)	1	
Career dental intern	1	
Medical student 1st 2 school years	62	Boston University School of Medicine, Boston, Mass.; Tufts University Medical School, Boston, Mass.
Medical student 2d 2 school years	263	Do.
Dental assistant trainee	28	Northeastern University, Boston Mass.
Dental hygienist trainee	22	Forsyth Dental Center School, Boston, Mass.
Dental laboratory technician trainee	1	
Dental student summer research trainee	1	School of Dental Medicine, Harvard University, Boston, Mass.
Basic nursing student	128	Boston University School of Nursing, Boston, Mass.
Graduate nursing student	18	Boston College School of Nursing, Newton, Mass.
Social work student (master's)	4	Boston University, Boston ,Mass.
Occupational therapist student	5	Tufts University, Boston, Mass.
Physical therapist student	8	Boston University, Boston, Mass.
Medical technologist student	9	
Certified laboratory assistant trainee	2	Blue Hills, Regional Technical Institute, Canton, Mass.
Radiologic technologist trainee	6	Northeastern University, Boston, Mass.
Research and education trainee	2	Tufts University Medical School, Boston, Mass.
Supply management trainee	1	
Assistant hospital director trainee	1	

BOSTON, MASS.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Medical technologist	$16,976	$16,976		0		8
Radiology technician trainee	11,500	11,000		0	$500	5
Basic nursing student	52,120	52,120		0		10
Total	80,596	80,096			500	23
NEW PROGRAMS						
Practical nurse student	108,241	87,795	$20,446	0		15
Total	108,241	87,795	20,446			15
Grand total	188,837	167,891	20,446	0	500	38

BOSTON, MASS.[1]

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Career dental resident	1	
Audiology and speech pathology student (doctoral).	2	Boston University, Boston, Mass.
Audiology and speech pathology student (master's).	1	Emerson College, Boston, Mass.
Psychology student (graduate)	7	Boston University, Boston, Mass.
Social work student (master's)	14	Boston College, Boston, Mass.; Smith College, North Hampton, Mass.; Boston University, Boston, Mass.; Simmons College, Boston, Mass.
Dietetic student	2	Framingham State College, Framingham, Mass.

[1] Outpatient clinic.

BROCKTON, MASS.

I. FISCAL YEAR 1970

Program	Number of trainees	Cooperating institutions
Dental intern (noncareer)	1	
Dental assistant trainee	19	Southeastern Regional Vocational Technical High School, South Easton, Mass.
Dental student summer research trainee	1	School of Dental Medicine, Harvard University, Boston, Mass.
Basic nursing student	138	Brockton Hospital, Brockton, Mass.; Boston City Hospital, Boston, Mass.; St. Luke's Hospital, New Bedford, Mass.; Cape Cod Community College, Hyannis, Mass.; Massasoit Community College, North Abington, Mass.
Psychology student (graduate)	16	Department of Psychology, Boston University, Boston, Mass.; Department of Psychology, Harvard University, Cambridge, Mass.; Graduate School, Catholic University of America, Washington, D.C.; Graduate School, University of Tennessee, Knoxville, Tenn.; Graduate School, Purdue University, Lafayette, Ind.
Social work student (doctoral)	4	Florence Heller School of Advanced Studies in Social Work, Brandeis University, Waltham, Mass.
Social work student (master's)	12	Boston College School of Social Work, Chestnut Hill, Mass.; Boston University School of Social Work, Boston, Mass.; Simmons College School of Social Work, Boston, Mass.
Occupational therapist student	13	Sargent College of Allied Health Professions, Boston University, Boston, Mass.; Tufts University, Bedford, Mass.; University of Florida, Gainesville, Fla.; SUNY at Buffalo, Buffalo, N.Y.
Manual arts therapist student	2	Gorham State College, Gorham, Maine; Rhode Island College, Providence, R.I.
Recreation specialist student	1	Boston University, Boston Mass.

BROCKTON, MASS.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Basic nursing student	$27,300		$27,000		$300	30
Social work student (MA)	140,000	$120,000	20,000			40
Occupational therapy	800	800				
Total	168,100	120,800	47,000		300	70
NEW PROGRAMS						
Dental laboratory technician	7,000		6,500		500	1
Professional nurse	9,100		9,000		100	24
Nursing assistant	132,000	80,000	50,000		2,000	50
Psychology student	884,400	778,600	55,000	$44,000	6,800	109
Social work assistant	270,000	250,000	20,000			50
Medical technicians	22,000		20,000		2,000	8
Management analyst	800	800				1
Personnel management specialist	8,098	8,098				1
Total	1,333,398	1,117,498	160,500	44,000	11,400	244
Grand total	1,501,498	1,238,298	207,500	44,000	11,700	314

NORTHAMPTON, MASS.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	100	Columbia Memorial Hospital, School of Nursing, Hudson, N.Y.; Cooley Dickinson Hospital, School of Nursing, Northampton, Mass.; Greenfield Community College, Greenfield, Mass.
Psychology student (graduate)	20	Psychology Department, University of Massachusetts, Amherst, Mass.; Springfield College, Springfield, Mass.
Vocational rehabilitation counselor student	3	Springfield College, Springfield, Mass.
Social work student (master's)	9	University of Connecticut, School of Social Work, West Hartford, Conn.
Occupational therapist student	17	Tufts University, Boston School of Occupational Therapy, Boston, Mass.; Temple University, Philadelphia, Pa.; College of St. Catherine, St. Paul, Minn.; State University of New York at Buffalo, Buffalo, N.Y.; University of Florida, Gainesville, Fla.; University of New Hampshire, Durham, N.H.; University of Puget Sound, Tacoma, Wash.; Virginia Commonwealth University, Richmond, Va.
Recreation specialist student	2	University of Massachusetts, Amherst, Mass.
Personnel management specialist trainee	2	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Social work student	$44,560	$26,560	$12,000	0	$6,000	8
Personnel management specialist trainee	8,100	8,100	0	0	0	1
Total	52,660	34,660	12,000		6,000	9
NEW PROGRAMS						
Mental health associate program	96,500	70,000	17,000	0	9,500	10
Total	96,500	70,000	17,000		9,500	10
Grand total	149,160	104,660	29,000		15,500	19

WEST ROXBURY, MASS.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	68	
Medical student 1st 2 school years	28	Harvard Medical School, Boston, Mass.; Tufts University School of Medicine, Boston, Mass.
Medical student 2d 2 school years	79	Harvard Medical School, Boston, Mass.
Dental assistant trainee	8	Blue Hills Regional Technical School, Canton, Mass.
Dental hygienist trainee	15	Forsythe School of Hygiene, Boston, Mass.
Basic nursing student	100	Northeastern University School of Nursing, Boston, Mass.; Newton Junior College School of Nursing, Newton, Mass.
Occupational therapist student	5	Boston University, Sargent College, Boston, Mass.; University of New Hampshire, School of Occupational Therapy, Durham, N.H.
Physical therapist student	20	Boston University, Sargent College, Boston, Mass.; Northeastern University, Bouve College, Boston, Mass.
Corrective therapist student	11	Boston University, School of Education, Boston, Mass.
Rehabilitation administration	2	Northeastern University, Boston, Mass.

ALLEN PARK, MICH.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	114	
Dental resident (noncareer)	2	
Dental intern (noncareer)	1	
Career dental resident	1	
Medical student 1st 2 school years	36	Wayne State University School of Medicine, Detroit, Mich.
Medical student 2d 2 school years	87	Do.
Basic nursing student	88	Wayne State University College of Nursing, Detroit, Mich.; Madonna College, Livonia, Mich.
Audiology and speech pathology student (doctoral).	11	Wayne State University, Detroit, Mich.
Psychology student (graduate)	22	Wayne State University, Detroit, Mich.; Michigan State University, East Lansing, Mich.; University of Michigan, Ann Arbor, Mich.
Social work student (master's)	14	Wayne State University, Detroit, Mich.; University of Michigan, Ann Arbor, Mich.
Medical technologist student	6	Wayne State University, Detroit, Mich.
Hospital librarian work-study trainee	1	Do.
Personnel management specialist trainee	2	
Graduate hospital administrator trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Audiology and speech pathology student	$81,648	$60,000	$15,327			10
Social work student	23,240	23,240				7
Medical technology student	20,241	20,421				9
Hospital librarian work-study trainee	7,294	7,294				1
Total	132,423	110,775	21,648			27
NEW PROGRAMS						
Pharmacy intern	37,151	24,294	12,857			3
Radiologic technologist trainee	43,964	31,606	12,358			5
Radioisotope technician trainee	6,321	6,321				1
Electrocardiograph technician trainee	5,629	5,629				1
Cardiopulmonary technician trainee	6,321	6,321				1
Director, voluntary	7,072	7,072				1
Total	106,458	81,243	25,215			12
Grand total	238,881	192,018	46,863			39

ANN ARBOR, MICH.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	247	
Medical intern	48	
Dental resident (noncareer)	2	
Medical student, 2d 2 school years	372	University of Michigan Medical School, Ann Arbor, Mich.
Basic nursing student	146	University of Michigan School of Nursing, Ann Arbor, Mich.
Graduate nursing student	27	Do.
Audiology and speech pathology student (doctoral).	8	University of Michigan, Ann Arbor, Mich.
Psychology student (graduate)	17	Wayne State University, Detroit, Mich.; Michigan State University, Lansing, Mich.; University of Michigan, Ann Arbor, Mich.
Social work student (master's)	6	Wayne State University, Detroit, Mich.; University of Michigan, Ann Arbor, Mich.
Occupational therapist student	3	Eastern Michigan University, Ypsilanti, Mich.
Physical therapist student	10	University of Michigan, Ann Arbor, Mich.
Pharmacy intern	1	
Dietetic intern affiliate	13	Do.
Hospital librarian work-study trainee	1	Do.
Radiologic technologist trainee	20	Washtenaw Community College, Ann Arbor, Mich.
Inhalation therapy technician trainee	10	Do.
Research and education trainee	2	University of Michigan Medical School, Ann Arbor, Mich.
Assistant hospital director trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
NEW PROGRAMS						
Dental assistant trainee	$22,000	$12,000	$10,000	None	None	2
Recreation therapy student	22,000	12,000	10,000	None	None	4
Physical therapy trainee	6,000	6,000	None	None	None	2
Pharmacy resident	56,000	40,000	14,000	None	$2,000	2
Pharmacy assistant	5,300	5,300	None	None	None	2
Physician assistant	56,000	30,000	12,000	$12,000	2,000	4
Total	167,300	105,300	46,000	12,000	4,000	16
EXPANDABLE PROGRAMS						
Nursing assistant trainee	60,000	46,000	12,000	None	2,000	30
Audiology and speech pathology student	6,000	6,000	None	None	None	1
Occupational therapy student	7,000	7,000	None	None	None	2
Physical therapy student	7,000	7,000	None	None	None	2
Pharmacy intern	48,400	32,400	14,000	None	2,000	4
Pharmacy student	12,000	12,000	None	None	None	4
Radiologic technician trainee (AMA)	13,140	3,640	4,000	3,500	2,000	2
Total	153,540	114,040	30,000	3,500	6,000	45
Grand total	320,840	219,340	76,000	15,500	10,000	61

BATTLE CREEK, MICH.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Audiology and speech pathology student (master's).	3	Western Michigan University, Kalamazoo, Mich.
Psychology student (graduate)	3	Michigan State University, East Lansing, Mich.
Social work student (master's)	6	University of Michigan, Ann Arbor, Mich.; Western Michigan University, Kalamazoo, Mich.
Social work student (baccalaureate)	1	Albion College, Albion, Mich.
Occupational therapist student	3	Western Michigan University, Kalamazoo, Mich.
Dietetic student	1	
Hospital librarian work-study trainee	1	Western Michigan University, Kalamazoo, Mich.
Hospital librarian student	1	Do.
Basic nursing student	52	Kellogg Community College, Battle Creek, Mich.

BATTLE CREEK, MICH.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Nursing assistants	$100,000	$75,000	$22,000	0	$3,000	160
Social week students	38,465	26,560	11,905	0	0	8
Total	138,465	101,560	33,905	0	3,000	168
NEW PROGRAMS						
Social work assistant	64,289	52,384	11,905	0	0	8
Medical technical trainee	19,804	11,706	8,098	0	0	2
Autopsy assistant trainee	5,853	5,853	0	0	0	1
Building management trainee	6,548	6,548	0	0	0	1
Laundry superintendent trainee	6,548	6,548	0	0	0	1
Supply management trainee	6,548	6,548	0	0	0	1
Personnel management trainee	6,548	6,548	0	0	0	1
Accountant trainee	6,548	6,548	0	0	0	1
Engineer trainee	8,098	8,098	0	0	0	1
Pharmacy assistant trainee	5,853	5,853	0	0	0	1
MAD trainee	6,548	6,548	0	0	0	1
Director voluntary services	8,098	8,098	0	0	0	1
Dental assistant	5,853	5,853	0	0	0	1
Total	157,136	137,133	20,003	0	0	21
Grand total	295,601	238,693	53,908	0	3,000	189

IRON MOUNTAIN, MICH.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Social work student (baccalaureate)	2	Northern Michigan University, Marquette, Mich.
Radiologic technologist trainee	5	Do.
Personnel management specialist trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
NEW PROGRAMS						
Graduate engineer trainee	$10,760	$10,760	0	0	0	1
Personnel management specialist trainee	8,840	8,840	0	0	0	1
Accountant trainee	8,840	8,840	0	0	0	1
Building management office trainee	8,840	8,840	0	0	0	1
Management analyst trainee	8,840	8,840	0	0	0	1
Supply management trainee	8,840	8,840	0	0	0	1
Medical administrative trainee	8,840	8,840	0	0	0	1
Total	63,800	63,800	0	0	0	7

SAGINAW, MICH.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	4	
Medical student 1st 2 school years	6	Michigan State University College of Human Medicine, East Lansing, Mich.
Basic nursing student	15	Delta College, University Center, Mich.
Practical nurse student	64	Saginaw Practical Nurse School, Saginaw, Mich.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Negative report.

MINNEAPOLIS, MINN.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	194	
Medical intern	12	
Career psychiatry resident	2	
Career radiology resident	1	
Career anesthesiology resident	1	
Career pathology resident	1	
Dental resident (noncareer)	1	
Career dental intern	1	
Medical student 2d 2 school years	125	University of Minnesota Medical School, Minneapolis, Minn.
Dental assistant trainee	30	Normandale State Junior College, Minneapolis, Minn.
Basic nursing student	139	St. Olaf's School of Nursing, Northfield, Minn.; Abbott School of Nursing, Minneapolis, Minn.; Mounds Midway School of Nursing, St. Paul, Minn.
Audiology and speech pathology student (doctoral).	2	University of Minnesota, Minneapolis, Minn.
Psychology student (graduate)	34	Mankato State College, Mankato, Minn.; University of Minnesota, Minneapolis, Minn.; University of North Dakota, Grand Forks, N.D.; University of North Carolina, Chapel Hill, N.C.
Social work student (master's)	20	University of Minnesota, Minneapolis, Minn.
Physical therapist student	6	Do.
Corrective therapist student	8	Mankato State College, Mankato, Minn.
Pharmacy intern	1	University of Minnesota, Minneapolis, Minn.
Pharmacy resident	2	Do.
Dietetic student	9	University of Minnesota, Minneapolis, Minn.; College of St. Catherine, St. Paul, Minn.; University of Colorado, Boulder, Colo.; Stout State University, Menomonie, Wis.
Medical technologist student	2	University of Minnesota, Minneapolis, Minn.
Medical technician trainee	5	Medical Institute of Minnesota, Minneapolis, Minn.; St. Paul Vocational Training Center, St. Paul, Minn.
Hospital librarian work-study trainee	1	University of Minnesota, Minneapolis, Minn.
Radiologic technologist trainee	22	
Medical student anesthesiology trainee	1	University of Oregon Medical School, Portland, Oreg.
Urology technician trainee	2	
Building management officer trainee	1	
Laundry superintendent trainee	1	
Graduate hospital administrator trainee	1	
Assistant hospital director trainee	1	
Biochemist	1	University of Minnesota, Minneapolis, Minn.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional or new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Graduate hospital administrator trainee	$17,500	$16,000			$1,500	1
Hospital administrator office trainee	17,500	16,000			1,500	1
Building management office trainee	8,098	8,098				1
Laundry supply trainee	8,716	8,716				1
Dental assistant	12,000	7,000			5,000	2
Medical technologist student	15,905		$11,905		4,000	2
Medical technician trainee						3
Hospital librarian workstudy trainee	3,200	3,200				1
Audiology and speech pathology student	14,640	6,640	7,000		1,000	2
Do	6,000	6,000				1
Basic nursing student diploma, associate and B.S	4,240				4,240	10
Pharmacy intern	23,160	23,160				3
Pharmacy resident	13,680	13,680				2
Occupational therapy student	25,712	5,950	19,762			28
Corrective therapy student B.S. or higher	13,600	3,600	10,000			16
Radiology technologist trainee	28,850	18,350	10,000		500	10
Social work student (B.S.)	14,000		14,000			33
Personnel management specialist trainee (non-VA affiliate)	8,300	8,100			200	1
Dietetic intern	926		836		90	13
Dietetic resident	11,066	8,098	2,898		70	2
Dietetic student	3,027		2,898		129	6
Do	198		178		20	20
Do	99		89		10	10
Total expandable programs	250,417	152,592	79,566		18,259	169

MINNEAPOLIS MINN.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
NEW PROGRAMS						
Dental hygiene	$30,000				$30,000	20
Electroencephalograph techincian trainee	47,245	$13,637	$21,608		12,000	6
Histopathology technician trainee	8,417	4,917			3,500	1
Dietitian's assistant	110,769	40,000	18,430		52,339	20
Total new programs	196,431	58,554	40,038		97,839	47
Grand total	446,848	211,146	119,604		116,098	216

ST. CLOUD, MINN.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	104	Dickinson State College, Dickinson, N. Dak.; St. Cloud School of Nursing, St. Cloud, Minn.; St. Gabriel School of Nursing, Little Falls, Minn.
Practical nursing student	86	Brainerd Area Vocational Technical School, Brainerd, Minn.; St. Cloud Area Vocational Technical School, St. Cloud, Minn.
Psychology student (graduate)	2	University of Minnesota, Minneapolis, Minn.; Ohio University, Columbus, Ohio.
Occupational therapist student	5	University of North Dakota, Grand Forks, N. Dak.; College of St. Catherine, St. Paul, Minn.; University of Kansas, Lawrence, Kans.
Manual arts therapist student	1	St. Cloud State College, St. Cloud, Minn.
Accountant trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Basic nursing student	$9,000		$9,000			80
Practical nurse student	4,500		4,500			30
Nursing assistant trainee	4,500		4,500			20
Vocational rehabilitation counselor student	14,192		14,192			2
Social work student	7,200		7,200			2
Occupational therapy student	45,836	$45,836				7
Manual arts therapist	32,740	32,740				5
Total	117,968	78,576	39,392			146
NEW PROGRAMS						
Dental laboratory technician trainee	7,000	7,000				1
Professional nurse trainee	30,000	24,000	6,000			24
Social work student	21,200	14,000	7,200			4
Physical therapist	6,548	6,548				1
Corrective therapist	13,096	13,096				2
Pharmacy intern	8,098	8,098				1
Food service worker trainee	11,898	11,898				2
Graduate engineer trainee	11,000	11,000				1
Personnel management specialist	8,098	8,098				1
Accountant trainee	9,000	9,000				1
Building management officer trainee	8,098	8,098				1
Supply management trainee	8,098	8,098				1
Mental health associate	95,000	70,000	25,000			10
Total	237,134	198,934	38,200			50
Grand total	355,102	277,510	77,592			196

BILOXI, MISS.[1]

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Career psychiatry resident	2	
Basic nursing student	48	Jackson County Junior, College, Pascagoula, Miss.; Jefferson Davis Junior College, Gulfport, Miss.; Providence Hospital School of Nursing, Mobile, Ala.
Practical nurse student	18	Jefferson Davis Junior College, Gulfport, Miss.
Psychology student (graduate)	3	University of Tennessee, Knoxville, Tenn.; University of Southern Mississippi, Hattiesburg, Miss.; University of Georgia, Athens, Ga.
Social work student (master's)	5	Atlanta University, Atlanta, Ga.; Louisiana State University, Baton Rouge, La.
Social work student (baccalaureate)	1	Mississippi State College for Women, Columbia, Miss.
Educational therapist student	1	University of Southern Mississippi, Hattiesburg, Miss.
Corrective therapist student	5	Do.
Personnel management specialist trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
NEW PROGRAMS						
Basic nursing student	$16,000	-------	$16,000	None	None	108
Practical nurse student	8,000	-------	8,000	None	None	18
Social work student	45,000	$33,000	12,000	None	None	10
Physical therapist student	4,500	-------	4,500	None	None	4
Manual arts therapist student	4,500	-------	4,500	None	None	4
Educational therapist student	9,000	-------	9,000	None	None	14
Corrective therapist student	9,000	-------	9,000	None	None	5
Medical technologist student	18,000	9,000	9,000	None	None	4
Total	114,000	42,000	72,000			167

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[1] Without compensation.

JACKSON, MISS.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	60	
Medical intern	19	
Career pathology resident	2	
Medical student 2d 2 school years	136	University of Mississippi School of Medicine, Jackson, Miss.
Psychology student (graduate)	2	University of Southern Mississippi, Hattiesburg, Miss.
Social work student (master's)	4	Louisiana State University, Baton Rouge, La.
Personnel management specialist trainee	1	
Supply management trainee	1	
Basic nursing student	13	St. Dominic's Hospital School of Nursing, Jackson, Miss.

JACKSON, MISS.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Social work student	$45,000	$24,000	$15,000	...	$6,000	2
Certified laboratory assistant	22,000	...	9,000	$10,000	3,000	6
Total	67,000	24,000	24,000	10,000	9,000	8
NEW PROGRAMS						
Basic nursing student	16,255	...	11,905	...	4,350	44
Practical nurse student	16,255	...	11,905	...	4,350	26
Nursing assistant	4,350	...	...	...	4,350	26
Social work student	46,000	25,000	15,000	...	6,000	10
Total	82,860	25,000	38,810	...	19,050	106
Grand total	149,860	49,000	62,810	10,000	28,050	114

JEFFERSON BARRACKS, MO.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Psychology student (graduate)	22	St. Louis University, St. Louis, Mo.; Washington University, St. Louis, Mo.; University of Missouri, Columbia, Mo.
Social work student (doctoral)	1	George Warren Brown School of Social Work, Washington University, St. Louis, Mo.
Social work student (master's)	7	George Warren Brown School of Social Work, Washington University, St. Louis, Mo.; School of Social Service, St. Louis University, St. Louis, Mo.
Physical therapist student	14	Washington University, St. Louis, Mo.; University of Missouri, Columbia, Mo.
Chaplain orientation trainee	17	
Basic nursing student	87	St. Louis Municipal Hospital, St. Louis, Mo.; St. Luke's Hospital School of Nursing, St. Louis, Mo.

KANSAS CITY, MO.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	79	
Medical intern	13	
Dental resident (noncareer)	3	
Career dental resident	2	
Career dental intern	3	
Medical student 2d 2 school years	213	University of Kansas School of Medicine, Kansas City, Kans.
Dental student summer research trainee	1	University of Missouri School of Dentistry, Kansas City, Mo.
Basic nursing student	47	University of Kansas, Kansas City, Kans.; Avila College, Kansas City, Mo.
Audiology and speech pathology student (master's).	10	University of Kansas, Kansas City, Kans.
Psychology student (graduate)	18	Kansas University, Lawrence, Kans.
Psychology student (postdoctoral)	2	Do.
Social work student (master's)	3	Do.
Social work student (baccalaureate)	3	Cooperative Social Welfare Action Program (COSWAP), Kansas City, Mo.
Occupational therapist student	28	University of Kansas, Kansas City, Kans.
Physical therapy assistant trainee	1	
Corrective therapy assistant trainee	1	
Dietetic intern affiliate	5	
Medical record technician trainee	1	
Chief nurse trainee	1	
Assistant hospital director trainee	2	
Microbiologist	3	Do.
Biochemist	4	Do.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Avila College nurse training program	$127			$127		8
K. U. graduate program	127			127		8
K. U nurse training program	127			127		10
Nurse refresher	10,000		$10,000			8
Nursing assistant trainee						8
Associate chief nurse for education training	15,611	$15,611				1
Supply management trainee	8,900	8,900			$150	1
Autopsy assistant	5,212	5,212				1
Postdoctoral audiology	30,937	12,000	18,437	100	400	2
Administrative intern	21,037	18,437		2,000	600	1
Graduate engineer trainee	8,900	8,900				1
Graduate social work trainee	10,000	10,000				2
Total	110,978	79,060	28,437	2,481	1,150	51
NEW PROGRAMS						
Fiscal assistant trainee	8,745	8,745				1
Recreation therapy						5
Dental assistant	22,998	10,800	8,948		3,250	6
Dental laboratory technician	30,223	8,320	15,403	2,500	4,000	2
Dental student summer research	3,600	2,400			1,200	2
Personnel management trainee	8,098	8,098				1
Nuclear medical technologist	8,700	7,200		1,000	500	2
Physician assistant	28,903	10,424	17,979		500	2
Total	111,267	55,987	42,330	3,500	9,450	21
Grand total	222,245	135,047	70,767	5,981	10,600	72

POPLAR BLUFF, MO.

I. FISCAL YEAR 1970

Training program name	Number of trainees	Cooperating institutions
Practical nursing student	24	Poplar Bluff School of Practical Nursing District Region 1, Poplar Bluff, Mo.

ST. LOUIS, MO.

I. FISCAL YEAR 1970

Training program name	Number of trainees	Cooperating institutions
Medical resident (noncareer)	142	
Medical intern	52	
Career pscyhiatry resident	3	
Career dental intern	1	
Medical student 2d 2 school years	148	Washington University School of Medicine, St. Louis, Mo.; St. Louis University School of Medicine, St. Louis, Mo.
Basic nursing student	106	Southern Illinois University, Edwardsville, Ill.; St. Louis University, St. Louis, Mo.; Forest Park Community College, St. Louis, Mo.
Audiology and speech pathology student (doctoral).	1	St. Louis University, St. Louis, Mo.
Audiology and speech pathology student (master's).	6	Do.
Audiology and speech pathology student (baccalaureate).	20	Fontbonne College, St. Louis, Mo.
Psychology student (graduate)	19	St. Louis University, St. Louis, Mo.; Washington University, St. Louis, Mo.; Texas Technological College, Lubbock, Tex.
Psychology student (postdoctoral)	1	St. Louis University, St. Louis, Mo.
Social work student (master's)	5	Washington University, St. Louis, Mo.; St. Louis University, St. Louis, Mo.
Occupational therapist student	3	Washington University, St. Louis, Mo.
Pharmacy intern	1	
Pharmacy student	3	St. Louis College of Pharmacy, St. Louis, Mo.
Certified laboratory assistant trainee	5	Forest Park Community College, St. Louis, Mo.
Nuclear medicine technician trainee	4	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Audiology and speech pathology	$31,752	$17,060	$14,192		$500	4
Psychology (graduate)	628,400	527,000	50,000	$45,000	6,400	85
Psychology (postdoctoral)	196,205	186,000	5,000	4,500	705	30
Social work student	28,536	9,960	12,976		5,600	3
Occupational therapist	6,640	6,640				2
Nuclear medicine technician	43,627	21,459	8,368	12,000	1,800	5
Total	935,160	768,119	90,536	61,500	15,005	129
NEW PROGRAMS						
Pharmacy interns	29,459	17,054	11,905		500	2
Pathology assistant	25,398	9,600	10,800		4,998	4
Personnel management specialist	8,826	8,826				1
Accountant	8,826	8,826				1
Building management	8,826	8,826				1
Management analyst	10,770	10,770				1
Supply management	8,826	8,826				1
Medical administrator	10,770	10,770				1
Total	111,701	83,498	22,705		5,498	12
Grand total	1,046,861	851,617	113,241	61,500	20,503	141

MILES CITY, MONT.

Training program	Number of trainees	Cooperating institutions
Basic nursing student	33	Miles Community College, Miles City, Mont.

GRAND ISLAND, NEBR.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Social work student (master's)	2	University of Nebraska, Lincoln, Nebr.

LINCOLN, NEBR.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	5	
Dental resident (noncareer)	7	
Basic nursing student	60	Union College School of Nursing, Lincoln, Nebr.; St. Elizabeth Hospital, Lincoln, Nebr.
Psychology student (graduate)	7	University of Nebraska Graduate School of Psychology, Lincoln, Nebr.
Social work student (master's)	2	University of Nebraska Graduate School of Social Work, Lincoln, Nebr.
Social work student (baccalaureate)	2	University of Nebraska, Lincoln, Nebr.
Physical therapist student	6	Nebraska Wesleyan University, Lincoln, Nebr.
Practical nursing student	37	Lincoln Public School of Practical Nursing, Lincoln Nebr.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
NEW PROGRAMS						
ASCP certified laboratory (total)	$35,000	$4,500	$18,000	$4,000	$8,000	5

Note: If the necessary funds and additional technical personnel were provided, we could qualify for the ASCP certified laboratory assistant training program. We would need two additional medical technologists to serve as workers and instructors.

OMAHA, NEBR.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	43	
Medical intern	36	
Career anesthesiology resident	2	
Dental resident (noncareer)	3	
Medical student (second 2 school years)	325	University of Nebraska College of Medicine, Omaha, Nebr.; Creighton University School of Medicine, Omaha, Nebr.
Dental assistant trainee	24	Omaha public schools, Omaha, Nebr.
Basic nursing student	141	University of Nebraska School of Nursing. Omaha, Nebr.; Nebraska Methodist School of Nursing, Omaha, Nebr.
Psychology student (graduate)	7	University of Nebraska Medical Center, Omaha, Nebr.
Social work student (baccalaureate)	3	University of Nebraska at Omaha, Omaha, Nebr.
Occupational therapy assistant trainee	2	
Physical therapy assistant trainee	2	
Medical student anesthesiology trainee	4	University of Nebraska Medical Center, Omaha, Nebr.
Electroencephalograph technician trainee	4	Douglas County Hospital, Omaha, Nebr.; Western Nebraska General Hospital, Scottsbluff, Nebr.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Social work trainee (M.S.) (total)	$18,412	$7,812	$10,600	0	0	2
NEW PROGRAMS						
Pharmacy intern	32,700	2,100	11,700	0	0	4
Dietetic intern	18,083	7,203	10,880	0	0	1
Certified laboratory assistant trainee	9,600	9,600	0	0	0	2
Historical technician	8,200	8,200	0	0	0	2
Autopsy assistant	8,200	8,200	0	0	0	2
Radioisotipe technician trainee	4,100	4,100	0	0	0	1
Inhalation therapy technician trainee	28,200	17,600	10,600	$200,000	0	4
Nuclear medicine technologist trainee	13,400	4,600	8,800	0	0	1

RENO, NEV.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	22	Orvis School of Nursing, University of Nevada, Reno, Nev.
Practical nursing student	31	MDTA, Reno, Nev.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
NEW PROGRAMS						
Nursing assistant trainee	$33,644	$23,105	$10,539			5
Physical therapy assistant trainee	9,242	9,242				2
Medical technologist student	4,498	4,498				2
Radiologic technologist trainee	4,498	4,498				2
Total	51,882	41,343	10,539			11

MANCHESTER, N.H.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	2	
Social work student (master's)	1	Boston College, Boston, Mass.
Basic nursing student	61	St. Anselm's College, Manchester, N.H.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Basic nursing student						20
Total						20
NEW PROGRAMS						
Dental hygienist trainee						2
Total						2
Grand total						22

EAST ORANGE, N.J.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	119	
Medical intern	14	
Career psychiatry resident	1	
Career neurology resident	1	
Career P.M. & R. resident	1	
Dental resident (noncareer)	2	
Career dental intern	2	
Medical student 1st 2 school years	80	New Jersey College of Medicine and Dentistry, Newark, N.J.
Medical student 2d 2 school years	83	Do.
Dental assistant trainee	13	Union County Technical Institute, Scotch Plains, N.J.
Basic nursing student	245	Seton Hall University, South Orange, N.J.; Fairleigh Dickinson University, Rutherford, N.J.; Rutgers University, New Brunswick, N.J.; Middlesex County College, Edison, N.J.; Orange Memorial Hospital, Orange, N.J.
Audiology and speech pathology student (master's).	4	Newark State College, Union, N.J.; Montclair State College, Montclair, N.J.
Psychology student (graduate)	23	Rutgers University, New Brunswick, N.J.; New York University. New York, N.Y.; Columbia University, New York, N.Y.; Fordham University, New York, N.Y.; Temple University, Philadelphia, Pa.; Yeshiva University, New York, N.Y.
Social work student (master's)	23	Rutgers University, New Brunswick, N.J.; Columbia University, New York, N.Y.
Dietetic resident	1	Rutgers University, New Brunswick, N.J.
Dietetic student	8	Douglas College, New Brunswick, N.J.; College of St. Elizabeth, Covent Station, N.J.
Hospital administration resident	1	
Graduate engineer trainee	1	
Building management officer trainee	1	
Graduate hospital administrative trainee	1	George Washington University, Washington, D.C.
Assistant hospital director trainee	2	

EAST ORANGE, N.J.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Basic nursing	$10,655	0	$9,655	$1,000	0	100
Audiology and speech pathology student (master's training)	6,640	$6,640	0	0	0	2
Social work student (M.A.)	19,920	19,920	0	0	0	6
Dietetic student	72	0	0	0	$72	4
Total	37,287	26,560	9,655	1,000	72	112
NEW PROGRAMS						
Practical nurse student	2,000	0	0	2,000	0	30
Social work student (B.A.)	13,905	0	11,905	2,000	0	8
Dietetic intern (non-VA)	500	0	0	0	500	6
Medical technologist	29,192	0	14,192	0	15,000	30
Radiologic technologist trainee	4,000	4,000	0	0	0	20
Inhalation therapy technician	18,000	18,000	0	0	0	3
Electrocardiograph technician	18,000	18,000	0	0	0	3
Electroencephalograph technician	18,000	18,000	0	0	0	3
Hemodialysis technician	18,000	18,000	0	0	0	3
Total	121,597	76,000	26,097	4,000	15,500	106
Grand total	158,884	102,560	35,752	5,000	15,572	218

LYONS, N.J.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	3	
Career psychiatry resident	3	
Basic nursing student	83	Muhlenberg Hospital, Plainfield, N.J.
Psychology student (graduate)	7	Rutgers University, New Brunswick, N.J.; Catholic University, Washington, D.C.
Social work student (master's)	7	Rutgers University, New Brunswick, N.J.
Social work student (baccalaureate)	5	Do.
Personnel management specialist trainee	2	Do.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Social work student (in master's degree training)	$116,180	$79,680	$24,000	$4,500	$8,000	10
Psychology trainee (postgraduate)	120,000	120,000	0	0	0	30
Psychology trainees (postdoctorate)	91,000	91,000	0	0	0	10
Total	327,180	290,680	24,000	4,500	8,000	50

ALBUQUERQUE, N. MEX.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	81	
Medical intern	22	
Career psychiatry resident	1	
Career radiology resident	1	
Career orthopedic surgery resident	1	
Career pathology resident	2	
Medical student 1st 2 school years	71	University of New Mexico School of Medicine, Albuquerque, N. Mex.
Medical student 2d 2 school years	47	Do.
Basic nursing student	65	University of New Mexico, Albuquerque, N. Mex.; University of Albuquerque, N. Mex.
Audiology and speech pathology student (doctoral).	1	University of New Mexico, Albuquerque, N. Mex.
Audiology and speech pathology student (master's).	5	do.
Audiology and speech pathology student (baccalaureate).	1	Do.
Occupational therapist student	1	Do.
Corrective therapist student	5	Do.
Medical technologist student	10	Do.
Research and education trainee	3	University of New Mexico School of Medicine, Albuquerque, N. Mex.
Hospital administration resident	1	Xavier University, Cincinnati, Ohio.
Personnel management specialist trainee	1	
Assistant hospital director trainee	1	
Practical nurse student	32	Technical Vocational Institute, Albuquerque, N. Mex.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Audiology and speech pathology trainees	$6,319	$3,319	$2,500	0	$500	1
NEW PROGRAMS						
Audiology and speech pathology trainee	6,638	6,638	0	0	0	2
Grand total	12,957	9,957	2,500	0	500	3

ALBANY, N.Y.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	97	
Medical intern	10	
Career readiology resident	3	
Career pathology resident	1	
Dental intern (noncareer)	1	
Career dental intern	1	
Medical student 1st 2 school years	80	Albany Medical College, Albany, N.Y.
Medical student 2d 2 school years	78	Do.
Dental assistant trainee	40	Hudson Valley Community College, Troy, N.Y.
Dental hygienist trainee	40	Do.
Basic nursing student	215	Hudson Valley Community College, Troy, N.Y.; Junior College of Albany, Albany, N.Y.; Fulton/Montgomery Community College, Troy, N.Y.; Russell Sage College, Troy, N.Y.
Graduate nursing student	17	Russell Sage College, Troy, N.Y.
Practical nursing student	91	MDTA, Albany, N.Y.
Audiology and speech psychology student (master's).	10	State University of New York, Albany, N.Y.
Social work student (master's)	4	Syracuse University, Syracuse, N.Y.; State University of New York, Albany, N.Y.

ALBANY, N.Y.—Continued

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Social work student (baccalaureate)	7	Skidmore College, Saratoga Springs, N.Y.; College of St. Rose, Albany, N.Y.
Physical therapist student	41	Russell Sage College, Troy, N.Y.
Pharmacy student in any school year	40	Albany College of Pharmacy, Albany, N.Y.
Dietetic student	1	University of Rochester, Rochester, N.Y.
Medical technologist student	12	Albany Medical Center Hospital, Albany, N.Y.; Russell Sage College, Troy, N.Y.; State University of New York, Albany, N.Y.; Colby Junior College, Waterville, Maine; Vermont College, Montpelier, Vt.
Cytotechnologist student	5	Albany Medical Center Hospital, Albany, N.Y.; St. Peter's Hospital, Albany, N.Y.; Cytology Screening, Inc., Albany, N.Y.; New York State Department of Health, Albany, N.Y.
Hospital librarian work-study trainee	1	State University of New York, Albany, N.Y.
X-ray technician trainee	16	Hudson Valley Community College, Troy, N.Y.
Nurse-anesthetist trainee	10	Albany Medical Center Hospital, Albany, N.Y.
Administrative intern	1	Ithaca College, Ithaca, N.Y.
Personnel management specialist trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
Audiology and speech pathologist	$52,770	$35,010	$16,760	$1,000	0	9
Social work graduates	21,800	13,200	7,100	1,500	0	4
Social work seniors	8,100	0	7,100	1,000	0	4
Physical therapy assistant	5,000	0	5,000	0	0	40
Dietetic summer practicum	3,000	3,000	0	0	0	1
Hospital librarian work-study trainee	6,548	6,548	0	0	0	1
Nurse anesthetist trainee	70,000	24,000	30,000	4,500	$11,500	3
Electron microscopy technician	30,800	4,800	20,000	3,000	3,000	4
Clinical hospital pharmacy residency program	51,976	35,284	14,792	500	1,400	4

BATAVIA, N.Y.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Psychology student (graduate)	4	University of Rochester, Rochester, N.Y.
Social work student (master's)	2	University of Buffalo, Buffalo, N.Y.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Social work	$31,920	$19,920	$12,000	0	0	5
Total	31,920	19,920	12,000	0	0	5
NEW PROGRAMS						
Basic nursing	$12,000	0	12,000	0	0	10
Nursing assistant	53,250	41,250	12,000	0	0	10
Practical nursing	12,000	0	12,000	0	0	10
Food service worker	62,100	54,000	8,100	0	0	10
Medical technician	26,900	18,800	8,100	0	0	4
Total	166,250	114,050	52,200	0	0	44
Grand total	198,170	132,970	64,200	0	0	49

BATH, N.Y.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	27	Keuka College, Keuka, N.Y.
Audiology and speech pathology student (master's).	13	State University of New York, Geneseo, N.Y.
Social work student (master's)	1	Syracuse University School of Social Work, Syracuse, N.Y.
Practical nurse student	30	Board of Cooperative Educational System, Bath, N.Y.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Basic nursing students	0	0	0	0	0	35
Audiology and speech pathology	0	0	0	0	0	12
Social work student	0	0	0	0	0	4
Practical nurse student	0	0	0	0	0	10
NEW PROGRAMS						
Recreation specialist student	0	0	0	0	0	2
Physical therapy assistant trainee	0	0	0	0	0	3
Medical technician trainee	0	0	0	0	0	4
Psychology student	0	0	0	0	0	4
Grand total	0	0	0	0	0	74

BRONX, N.Y.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	125	
Career psychiatry resident	2	
Career radiology resident	8	
Career pathology resident	2	
Dental resident (noncareer)	2	
Dental intern (noncareer)	1	
Career dental resident	1	
Medical student, 1st 2 school years	60	Mount Sinai School of Medicine, New York, N.Y.; Albert Einstein College of Medicine, New York, N.Y.; Columbia University College of Physicians and Surgeons, New York, N.Y.
Medical student, 2d 2 school years	51	Mount Sinai School of Medicine, New York, N.Y.; Albert Einstein College of Medicine, New York, N.Y.; Columbia University College of Physicians and Surgeons, New York, N.Y.
Dental student summer research trainee	1	Columbia University, New York, N.Y.
Audiology and speech pathology student (doctoral).	4	Do.
Audiology and speech pathology student (master's).	20	Do.
Psychology student (graduate)	18	New York University, New York, N.Y.; Columbia University, New York, N.Y.; Yeshiva University, New York, N.Y.; Fordham University, New York, N.Y.
Social work student (master's)	4	Columbia University, New York, N.Y.
Occupational therapist student	23	Columbia University, New York, N.Y.; Wayne State University, Detroit, Mich.; Virginia Commonwealth University, Richmond, Va.; University of Kansas, Lawrence, Kans.; New Hampshire University, Durham, N.H.; University of Florida, Gainesville, Fla.; Western Michigan University, Kalamazoo, Mich.; Temple University, Philadelphia, Pa.; St. Catherine College, St. Paul, Minn.; University of New York at Buffalo, Buffalo, N.Y.; Boston University, Boston, Mass.; Tufts University, Bedford, Mass.; New York University, New York, N.Y.; University of Wisconsin, Madison, Wis.; Eastern Michigan University, Ypsilanti, Mich.; Ohio University, Columbus, Ohio.
Physical therapist student	20	Ithaca College, Ithaca, N.Y.; New York University, New York, N.Y.; Columbia University, New York, N.Y.; University of Puerto Rico, Rio Piedras, P.R.; Downstate Medical University, SUNY, New York, N.Y.
Dietetic intern	25	
Personnel management specialist trainee	1	

BRONX, N.Y.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training programs	Additional dollars needed: Total	Stipends	Instructors salaries	Space	Other cost	Number of additional or new trainees
EXPANDABLE PROGRAMS						
Audiology and speech pathology (in doctoral training)						3
Audiology and speech pathology (master's training)	$18,000	$18,000				3
Social work student (master's training)	47,392	33,200	$14,192			10
Occupational therapist (baccalaureate or higher training)	42,512	22,750	19,762			7
Physical therapist student (baccalaureate or higher training)	16,250	16,250				5
Manual arts therapist student (baccalaureate or higher training)	13,000	13,000				4
Educational therapist student (baccalaureate or higher training)	9,750	9,750				3
Corrective therapist	13,000	13,000				4
Recreational specialist	9,750	9,750				3
Dietetic intern	14,588	14,588				2
Audiology and speech pathology	18,000	18,000				6
Social work student	47,392	33,200	14,192			10
Occupational therapist	42,512	22,750	19,762			7
Physical therapist	16,250	16,250				5
Manual arts therapist	13,000	13,000				4
Educational therapist	9,750	9,750				3
Total	331,146	263,238	67,908			44
NEW PROGRAMS						
Vocational rehabilitation councils	11,981		11,981			3
Electrocardio technology	5,853	5,853				1
Hemodialysis technology	5,853	5,853				1
Urology technology	5,853	5,853				1
Gastroenterology technology	5,853	5,853				1
Total	35,393	23,412	11,981			7
Grand total	366,539	286,650	45,935			51

BROOKLYN, N.Y.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	113	
Medical intern	2	
Dental resident (noncareer)	2	
Dental intern (noncareer)	3	
Medical student second 2 school years	12	SUNY College of Medicine, Downstate Medical Center, Brooklyn, N.Y.
Dental hygienist trainee	5	New York City Community College, Brooklyn, N.Y.
Basic nursing student	610	Methodist Hospital, Brooklyn, N.Y.; Kingsborough Community, Brooklyn, N.Y.; Staten Island Community, Staten Island, N.Y.; State University of New York, Brooklyn, N.Y.; Long Island University, Brooklyn, N.Y.; Wagner College, Staten Island, N.Y.
Practical nurse student	160	New York Board of Education, MDTA.
Audiology and speech pathology student (doctoral).	2	Columbia University, New York, N.Y.
Audiology and speech pathology student (master's).	8	Do.
Psychology student (graduate)	17	Do. New York University, New York, N.Y.
Social work student (master's)	3	Adelphi University, Long Island, N.Y.
Physical therapist student	2	Downstate Medical Center, Brooklyn, N.Y.
Corrective therapist student	4	Long Island University, Brooklyn, N.Y.
Medical technologist student	4	Long Island University, Brooklyn, N.Y.; C. W. Post College, Long Island, N.Y.; Pace College, New York, N.Y.; Richmond College, Staten Island, N.Y.
Medical technician trainee	5	New York City Community College, Brooklyn, N.Y.
Chaplain resident	3	U.S. Army, Fort Hamilton, N.Y.
Personnel management specialist trainee	1	
Laundry superintendent trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPENDABLE PROGRAMS						
Speech-pathology and audiology	$65,750	$10,000	$27,000	$12,000	$16,750	
Medical technology	68,789	31,830	16,959	None	20,000	15
Total	134,539	41,830	43,959	12,000	36,750	
NEW PROGRAMS						
Professional nurses training (refresher)	30,600	30,600		None		8
Radiology service	99,520	44,520	26,000	2,000	27,000	6
Technology training inhalation therapy	57,000	20,000	30,000	2,000	5,000	
Nurse anesthetist program	101,564	60,000	37,000	None	4,564	6
Supply management	10,282	10,157			125	1
Total	298,966	165,277	93,000	4,000	36,689	
Grand total	433,505	207,107	136,959	16,00	73,439	

BROOKLYN, N.Y.[1]

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Psychology student (graduate)	18	Fordham University, New York, N.Y.; New York University, New York, N.Y.; Columbia University, New York, N.Y.; Yeshiva University, New York, N.Y.
Social work student (master's)	7	Columbia University, New York, N.Y.; Hunter College, New York, N.Y.

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[1] Outpatient Clinic

BUFFALO, N.Y.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	58	
Dental resident (noncareer)	1	
Career dental resident	3	
Career dental intern	1	
Medical student 1st 2 school years	212	State University of New York at Buffalo School of Medicine, Buffalo, N.Y.
Medical student 2d 2 school years	93	Do.
Dental student 2d 2 school years	73	State University of New York at Buffalo School of Dentistry, Buffalo, N.Y:
Dental assistant trainee	15	Niagara Community College, Niagara Falls, N.Y.; Buffalo Urban League, Buffalo, N.Y.
Dental hygienist trainee	3	Niagara Community College, Niagara Falls, N.Y.; Erie Community College, Buffalo, N.Y.
Basic nursing student	219	D'Youville College, Buffalo, N.Y.; State University of New York at Buffalo, Buffalo, N.Y.
Graduate nursing student	8	State University of New York at Buffalo, Buffalo, N.Y.
Audiology and speech pathology student (master's).	3	Do.
Audiology and speech pathology student (baccalaureate).	3	Do.
Psychology student (graduate)	39	State University of New York at Buffalo, Buffalo, N.Y.; Rochester University, Rochester, N.Y.; Ohio State University, Columbus, Ohio.
Social work student (baccalaureate)	4	State University of New York at Buffalo, Buffalo, N.Y.
Occupational therapist student	24	State University of New York at Buffalo, Buffalo, N.Y.; Eastern Michigan University, Ypsilanti, Mich.
Physical therapist student	28	State University of New York at Buffalo, Buffalo, N.Y.
Manual arts therapist student	4	State University College at Buffalo, Buffalo, N.Y.
Recreation specialist student	34	Erie Community College, Buffalo, N.Y.; State University College at Cortland, Cortland, N.Y.
Pharmacy intern	2	State University of New York at Buffalo School of Pharmacy, Buffalo, N.Y.
Pharmacy student	7	Do.
Medical technologist student	16	State University of New York at Buffalo, Buffalo, N.Y.
Hospital librarian work-study trainee	1	State University of New York at Buffalo, Buffalo, N.Y.; State University of New York at Geneseo, Geneseo, N.Y.
Personnel management specialist trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Basic nursing student (baccalaureate programs)	$5,212				$5,212	75
Graduate nursing student (in master's degree program)	0					2
Practical nurse student (in training programs, preparing for licensure exam)	0					30
Nursing assistant trainee (all levels)	65,972		$46,210	$19,762		10
Social work student (in master's degree training)	38,843	$16,600	13,493	7,500	1,250	5
Social work student (in baccalaureate training)	22,493		13,493	7,500	1,500	6
Pharmacy intern	8,956	8,956				2
Hospital librarian work-study trainee	17,646	8,098	7,048	2,000	500	1
Personnel management specialist trainee	7,728	7,728				1
Total	166,850	87,592	53,796	17,000	8,462	132
NEW PROGRAMS						
Dental laboratory technician trainee	5,212	5,212				1
Social work assistant trainee (holder of bachelor's degree, in training at VA station to assist social worker)	6,480	5,980			500	2
Dietetic intern affiliate	4,940		4,940			2
Hospital librarian student	6,548	6,548				1
Radioisotope technician trainee	41,196	16,196	20,000		5,000	2
Hemodialysis technician trainee	38,000	8,000	30,000			2
Cardiopulmonary technician trainee	38,000	8,000	30,000			2
Graduate engineer trainee	10,528	10,528				1
Medical student summer fellowship (P.M. & R.)	1,090	1,090				1
Regional medical programs (cardiology and respiratory nursing)	9,881		9,881			10
Total	161,875	61,554	94,821		5,500	24
Grand total	328,725	149,146	148,617	17,000	13,962	156

CANANDAIGUA, N.Y.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	345	Community College of the Finger Lakes, Canandaigua N.Y.; Roberts Wesleyan College, Rochester (Chili) N.Y.; Keuka College, Penn Yan (Keuka Park), N.Y.
Practical nurse student	34	St. Francis Hospital, Olean, N.Y.
Psychology student (graduate)	5	University of Rochester, Rochester, N.Y.
Social work student (master's)	1	Syracuse University, Syracuse, N.Y.
Dietetic student	4	Community College of the Finger Lakes, Canandaigua, N.Y.

CASTLE POINT, N.Y.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	8	
Basic nursing student	22	St. Francis Hospital, Poughkeepsie, N.Y.
Practical nursing student	21	Poughkeepsie School of Practical Nursing, Poughkeepsie, N.Y.
Psychology student (graduate)	1	University of Southern Illinois, Carbondale, Ill.

CASTLE POINT, N.Y.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
NEW PROGRAMS						
Spinal cord injury nursing	$108,000	$85,000	$12,000	0	$11,000	10
P.M. & R. occupation therapy assistant trainee	41,000	30,000	11,000	0	0	5
P.M. & R. physical therapy assistant trainee	41,000	30,000	11,000	0	0	5
P.M. & R. corrective therapy assistant trainee	41,000	30,000	11,000	0	0	5
Total	231,000	175,000	45,000	0	11,000	25

MONTROSE, N.Y.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Dental intern (noncareer)	1	
Basic nursing student	163	St. Joseph's Hospital School of Nursing, Elmira, N.Y.; Arnot-Ogden Memorial Hospital School of Nursing, Elmira, N.Y.; Auburn Memorial Hospital School of Nursing, Auburn, N.Y.; Elizabeth General Hospital School of Nursing, Elizabeth, N.J.; Pace College School of Nursing, Pleasantville, N.Y.
Practical nurse student	40	Board of Cooperative Education Services School of Nursing, Yorktown Heights, N.Y.
Psychology student (graduate)	25	University of North Carolina, Durham, N.C.; Yeshiva University, Bronx, N.Y.; Fordham University, Bronx, N.Y.; Adelphi, Long Island City, N.Y.; Columbia University, New York City; New York University, New York City.
Social work student (master's)	4	Hunter College, New York City; Yeshiva University, Bronx, N.Y.
Physical therapist student	9	Ithaca College, Ithaca, N.Y.; New York University, New York City; Columbia University, New York City.
Personnel management specialist trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
NEW PROGRAMS						
Medical technician trainee	$5,000	$5,000	0	0	0	1
Total	5,000	5,000	0	0	0	1

NEW YORK, N.Y.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	274	
Medical intern	86	
Career psychiatry resident	7	
Career P.M. & R. resident	2	
Career anesthesiology resident	1	
Career pathology resident	2	
Dental resident (noncareer)	8	
Dental intern (noncareer)	9	
Career dental resident	4	
Medical student first 2 school years	10	New York University School of Medicine, New York, N.Y.
Medical student second 2 school years	114	Do.
Basic nursing student	182	Hunter College, New York, N.Y.; Skidmore College, New York, N.Y.
Practical nurse student	552	MDTP, New York, N.Y.; Job Corps, Jersey City, N.J.
Audiology and speech pathology student (doctoral).	2	Columbia University, New York, N.Y.; New York University, New York, N.Y.
Audiology and speech pathology student (master's).	10	Columbia University, New York, N.Y.; Hunter College, New York, N.Y.; City University of New York, New York, N.Y.
Audiology and speech pathology student (baccalaureate).	1	Hunter College, New York, N.Y.
Psychology student (graduate)	27	Teachers College, Columbia University, New York, N.Y.; Fordham University, New York, N.Y.; New York University, New York, N.Y.; Adelphi University, New York, N.Y.; University of Rochester, Rochester, N.Y.; University of Massachusetts, Amherst, Mass.
Psychology student (graduate) (continued)		Penn State University, University Park, Pa.
Social work student (master's)	18	Fordham University, New York, N.Y.; Columbia University, New York, N.Y.
Social work student (baccalaureate)	3	New York University, New York, N.Y.
Occupational therapy assistant trainee	9	Columbia University, New York, N.Y.; Downstate Medical Center, Brooklyn, N.Y.
Physical therapy assistant trainee	12	Albert Einstein Medical College, Bronx, N.Y.; Columbia University, New York, N.Y.
Dietetic student	4	New York University, New York, N.Y.
Nurse-anesthetist trainee	3	
Chief nurse trainee	1	
Hospital administration resident	1	
Accountant trainee	1	
Assistant hospital director trainee	2	
Graduate nursing student	25	New York University, New York, N.Y.; Teacher's College, Columbia University, New York, N.Y.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Speech pathologist	$87,940	$72,940	$15,000			14
Social work student	97,840	39,840	20,000			12
Occupational therapy student	66,500	45,500	20,000	$25,000	$13,000	14
Physical therapy student	65,500	45,500	20,000		1,000	14
Pharmacy intern	31,000	17,000	14,000			2
Total	348,780	220,780	89,000	25,000	14,000	56
NEW PROGRAMS						
Dental assistant	14,000	14,000				7
Dental laboratory technician	125,000	125,000				5
Professional nurse trainee	132,000	120,000	12,000			12
Nursing assistant	80,000	60,000	20,000			30
Audloogy and speech pathology student	48,250	16,250	15,000	10,000	7,000	5
Mainual arts therapist student	59,000	39,000	20,000			12
Educational therapist student	59,000	39,000	20,000			12
Correctional therapist student	24,000	13,000	11,000			4
Recreational specialist student	59,000	39,000	20,000			12
Blind rehabilitation student	59,500	39,000	20,000		500	12
Occupational therapy assistant trainee	52,500	32,000	20,000		500	16

NEW YORK, N.Y.—Continued

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Trainingf program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
NEW PROGRAMS—Continued						
Physical therapy assistant trainee	$52,500	$32,000	$20,000		$500	1
Manual arts therapy assistant trainee	30,500	20,000	10,000		500	10
Educational therapy assistant trainee	30,500	20,000	10,000		500	10
Correctional therapy assistant trainee	26,000	16,000	10,000			8
General P.M. & R. assistant trainee	56,500	36,000	20,000		500	18
Pharmacy student	6,500	6,500				2
Food service worker trainee	70,000	60,000	10,000			30
Medical technologist student	28,747	6,747	12,000	$10,000		3
Certified laboratory assistant trainee	28,747	6,747	12,000	10,000		3
X-ray technician trainee	46,984	35,984	10,000		1,000	16
Radioisotope technician trainee	7,498	4,498			3,000	2
Medical record library trainee	3,250	3,250				1
Medical record library trainee	2,000	2,000				1
Inhalation therapy technician trainee	46,490	22,490	24,000			10
Nurse anesthetist trainee	64,000	40,000	24,000			10
Medical student anesthesiologist	20,100	20,100				6
Electrocardiograph technician trainee	8,996	8,996				4
Extracorporeal performance technician	3,250	3,250				1
Monitory technician trainee	6,747	6,747				3
Operating room technician trainee	42,731	42,731				19
Accountant trainee	21,800	9,000	12,000		800	3
Laundry superintendent trainee	3,000	3,000				1
Supply management trainee	6,700	6,700				2
Total	1,325,790	948,990	332,000	30,000	14,800	306
Grand total	1,674,570	1,169,770	421,000	55,000	28,800	362

VA PROSTHETICS CENTER, NEW YORK, N.Y.,

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Orthotist-prosthetist trainee	12	
Restoration technician trainee	2	

NORTHPORT, N.Y.,

I. FISCAL YEAR 1970

Training program	Number of of trainees	Cooperating institutions
Career psychiatry resident	2	
Dental hygienist trainee	90	State University of N.Y., Farmingdale, N.Y.
Basic nursing student	152	State University of N.Y., Farmingdale, N.Y.; Nassau Community College, Garden City, N.Y.
Graduate nursing student	1	Adelphi University, Garden City, N.Y.
Psychology student (graduate)	24	Teachers College, Columbia University, New York, N.Y.; State University of New York at Stonybrook, Stonybrook, N.Y.; Texas Technological University, Lubbock, Tex.; Catholic University, Washington, D.C.; Fordham University, Bronx, N.Y.; Adelphi University, Garden City, N.Y.; University of North Carolina, Chapel Hill, N.C.; University of Tennessee, Knoxville, Tenn.; Long Island University, Brooklyn, N.Y.; City College, City University of New York, New York, N.Y.; Yeshiva University, New York, N.Y.; Colgate University, Hamilton, N.Y.; New York University, New York, N.Y.
Social work student (master's)	4	Adelphi University, Garden City, N.Y.; Hunter College, New York, N.Y.
Occupational therapist student	18	Virginia Commonwealth University, Richmond, Va.; University of Puerto Rico, San Juan, P.R.; Sargent College, Boston University, Boston, Mass.; New York University, New York, N.Y.; Temple University, Philadelphia, Pa.; Tufts University, Boston, Mass.; West Michigan University, Kalamazoo, Mich.
Physical therapist student	3	Ithaca College, Ithaca, N.Y.
Personnel management specialist trainee	1	

NORTHPORT, N.Y.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructors salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Dental assistant trainee	$84,000		$14,000	$22,000	$48,000	40
Dental hygienist trainee	22,000		12,000	6,000	4,000	50
Nursing assistant trainee	146,720	$114,720	28,000	3,500	500	80
Social work student (in masters degree training)	55,284	33,200	16,084	4,000	2,000	10
Occupational therapist student (in baccalaureate or higher training)	7,128	7,128				9
Personnel management	16,196	16,196				2
Total (6)	331,328	171,244	70,084	35,500	54,500	191
NEW PROGRAMS						
Basic nursing student (ADN)	45,500		42,000	3,500		24
Practical nurse, student	17,500		14,000	3,500		16
Professional nurse (trainee refresher)	44,922	30,672	14,000		250	12
Social work student (in baccalaureate training)	45,624	27,540	16,084	2,000		10
Physical therapy, student						15
Corrective therapy, student						5
Recreation specialist						5
Autopsy assistant, trainee	5,212	5,212				1
Radiologic technologist trainee	96,130		68,780	10,000	17,350	16
Medical record librarian trainee	16,196	16,196				2
Medical record technician trainee	13,096	13,096				2
Inhalation therapy technician	24,700	13,500	3,000		8,200	6
Cardiopulmonary technician	11,000	9,000	1,000		1,000	4
Accountant trainee	8,223	8,098			125	1
Medical administrative trainee (assistant chief, Medical Administration Division trainee)	19,762	19,762				2
Director, voluntary service trainee	21,816	17,816		500	3,500	2
Total (16)	369,681	160,892	158,864	19,500	30,425	123
Grand total (22)	701,009	332,136	228,948	55,000	84,925	314

SYRACUSE, N.Y.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	108	
Medical intern	40	
Career psychiatry resident	1	
Career anesthesiology resident	1	
Medical student 1st 2 school years	101	State University of New York College of Medicine, Syracuse, N.Y.
Medical student 2d 2 school years	123	State University of New York College of Medicine, Syracuse, N.Y.
Basic nursing student	90	Syracuse University School of Nursing, Syracuse, N.Y.
Graduate nursing student	1	Do.
Practical nurse student	115	MDTA, Syracuse, N.Y.
Audiology and speech pathology student (doctoral).	1	Syracuse University, Syracuse, N.Y.
Audiology and speech pathology student (master's).	5	Do.
Psychology student (graduate)	25	University of Rochester, Rochester, N.Y.; Syracuse University, Syracuse, N.Y.
Psychology student (baccalaureate)	13	Colgate University, Hamilton, N.Y.
Social work student (master's)	6	Syracuse University, Syracuse, N.Y.
Social work student (baccalaureate)	2	St. Lawrence University, Canton, N.Y.
Hospital librarian work-study trainee	1	Syracuse University School of Library Sciences, Syracuse, N.Y.

SYRACUSE, N.Y.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed — Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE						
Audiology and speech pathology student (in doctoral or post-doctoral training)	$26,370	$10,420	$15,750		$200	2
Audiology and speech pathology student (in master's degree training)	4,090	3,890			200	1
Psychology student (in baccalaureate training)	23,050	4,800	15,750	$2,000	500	4
Social work student (in baccalaureate training)	9,170	8,970			200	3
Hospital librarian work-study trainee	6,748	6,548			200	
Total	69,428	34,628	31,500	2,000	1,300	10
NEW PROGRAMS						
Occupational therapy assistant trainee (all levels below therapist)	8,750	8,250			500	2
Physical therapy assistant trainee (all levels below therapist)	8,750	8,250			500	2
Dietetic student (in baccalaureate training)	3,127	2,927			200	1
Food service worker trainee (all levels)	33,273	20,625	11,648		1,000	10
Medical technician trainee (laboratory training for other than certified status, e.g., laboratory technician, laboratory assistant, laboratory aide, etc., at all levels)	8,750	8,250			500	2
Radiologic technologist trainee—also known as medical radiology technician, medical radiological technician, X-ray technician, etc. (in program approved by AMA Council on Medical Education)	12,600	5,212	11,648		200	1
Inhalation therapy technician trainee—all levels (in other than program approved by AMA Council on Medical Education)	8,750	8,250			500	2
Surgery technician trainee (general)	8,750	8,250			500	2
Psychology research technician	34,478	12,478	20,000	1,000	1,000	2
Psychological rehabilitation counselor	38,980	21,230	15,750	1,000	1,000	2
Hospital administration resident	7,494	7,294			200	1
Total	173,162	111,016	59,046	2,000	6,100	27
Grand total	242,590	145,644	90,546	4,000	7,400	37

DURHAM, N.C.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	182	
Medical intern	46	
Career psychiatry resident	3	
Career pathology resident	1	
Dental resident (noncareer)	2	
Medical student 1st 2 school years	88	Duke University school of Medicine, Durham, N.C.
Medical student 2d 2 school years	66	Do.
Basic nursing student	105	Duke University School of Nursing, Durham, N.C.; North Carolina Central University, School of Nursing, Durham, N.C.; University of North Carolina School of Nursing, Chapel Hill, N.C.
Audiology and speech pathology student (mas-(master's).	2	University of North Carolina at Greensboro, Greensboro, N.C.
Psychology student (graduate)	22	Duke University, Durham, N.C.; University of North Carolina, Chapel Hill, N.C.

DURHAM, N.C.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Social work student (master's)	5	University of North Carolina School of Social Work Chapel Hill, N.C.
Physical therapist student	4	Duke University, Durham, N.C.
Dietetic intern affiliate	25	Do.
Medical technologist student	7	Do.
Pathologist's assistant trainee	3	Do.
Radiologic technologist trainee	45	Do.
Radiologist's assistant trainee	2	
Physician's assistant trainee	4	
Research and education trainee	6	Duke University School of Medicine, Durham, N.C.
Hospital administration resident	12	Duke University, Durham, N.C.
Personnel management specialist trainee	1	
Assistant hospital director trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Physician's assistant	$200,000	$120,000	$40,000		$40,000	20
Pathology assistant	36,700	19,200	10,000		7,500	6
Total	236,700	139,200	50,000		47,500	26
NEW PROGRAMS						
Dietetic interns	45,000	15,000	15,000		15,000	8
Pharmacy intern	7,938	6,938			1,000	1
Physical therapist	39,000	9,000	30,000			20
Radiation therapist	30,000	15,000	10,000		5,000	6
Radiation technician	50,000	25,000	15,000		10,000	10
Nuclear medicine	15,500	7,500	5,000		3,000	3
Total	187,438	78,438	75,000		34,000	48
Grand total	424,138	217,638	125,000		81,500	74

FAYETTEVILLE, N.C.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	121	Fayetteville Technical Institute—Fayetteville, N.C.; Highsmith-Rainey Memorial Hospital—Fayetteville, N.C.; Sandhills Community College—Southern Pines, N.C.
Physical therapy assistant trainee	3	Project Transition—U.S. Army, Fort Bragg, N.C.
Medical technician trainee	1	Do.
X-ray technician trainee	3	Do.
Electrocardiograph technician trainee	1	Do.
Hospital cook	1	Do.
Medical secretary	1	Worth College—Fayetteville, N.C.

FAYETTEVILLE, N.C.

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Basic nursing student	0	0	0	0	0	12
Medical secretary training	$2,156	$2,156	0	0	0	3
Total	2,156	2,156	0	0	0	15
NEW PROGRAMS						
Occupational therapy assistant trainee	0	0	0	0	0	1
Dietetic student	1,178	1,178	0	0	0	1
Total	1,178	1,178	0	0	0	2
Grand total	3,334	3,334	0	0	0	17

OTEEN, N.C.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	10	
Basic nursing student	120	Greenville General Hospital School of Nursing, Greenville, N.C.; Eastern Carolina University, Greenville, N.C.
Psychology student (graduate)	1	University of Georgia, Athens, Ga.
Psychology student (baccalaureate)	1	Lincoln University, Lincoln, Pa.
Social work student (master's)	2	University of North Carolina, Chapel Hill, N.C.
Occupational therapist student	6	University of Wisconsin, Madison, Wis.; Washington University, St. Louis, Mo.
Assistant hospital director trainee	2	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
NEW PROGRAMS						
Basic nursing student	$30,000				$30,000	150
Professional nurse trainee	400				400	2
Nursing assistant	2,000				2,000	10
Physical therapist student	400				400	2
Manual arts therapist student	400				400	2
Corrective therapist student	400				400	2
Occupational therapist assistant trainee	400				400	2
Physical therapist assistant trainee	400				400	2
Manual arts therapist assistant trainee	400				400	2
Corrective therapy assistant trainee	400				400	2
General P.M. & R. assistant trainee	400				400	2
Food service worker trainee	1,000				1,000	10
Certified laboratory assistant trainee	400				400	2
Medical technician trainee	400				400	2
X-ray technician trainee	400				400	2
Inhalation therapy trainee	200				200	1
Electrocardiograph trainee	200				200	1
Cardiopulmonary function technician trainee	200				200	1
Nuclear medicine technician trainee	200				200	1
General surgery technician trainee	200				200	1
Monitoring technician trainee	200				200	1
O.R. technician trainee	200				200	1
Thoracic surgery technician trainee	200				200	1
Personnel specialist trainee	7,200	$7,000			200	1
Laundry superintendent trainee	7,200	7,000			200	1
Management analyst trainee	9,200	9,000			200	1
Total	63,000	23,000			40,000	205

75

SALISBURY, N.C.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Dental assistant trainee	15	Guilford Technical Institute, Jamestown, N.C.
Dental hygienist trainee	31	Central Piedmont Community College, Charlotte, N.C.
Basic nursing student	31	University of North Carolina, Greensboro, N.C.
Psychology student (graduate)	8	University of South Carolina, Columbia, S.C.; University of North Carolina, Chapel Hill, N.C.; University of Tennessee, Knoxville, Tenn.; Davidson University, Davidson, N.C.; Wake Forest, Winston-Salem, N.C.
Social work student (master's)	13	University of North Carolina, Chapel Hill, N.C.; University of North Carolina, Charlotte, N.C.; University of Georgia, Athens, Ga.
Social work student (baccalaureate)	10	North Carolina A. & T. State University, Greensboro, N.C.
Personnel management specialist trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
NEW PROGRAMS						
Dental laboratory technician trainee	$17,800	$4,800	$10,000	0	$3,000	2
Psychology students (in baccalaureate training)	11,380	10,980	0	0	400	3
Social work student (baccalaureate training)	25,454	8,970	16,084	0	400	3
Social work assistant trainee	10,360	9,960	0	0	400	3
Occupational therapist student	11,050	9,750	0	0	1,300	3
Physical therapy student	10,050	9,750	0	0	300	3
MAT student	11,050	9,750	0	0	1,300	3
Educational therapy student	6,800	6,500	0	0	300	2
Corrective therapy student	10,150	9,750	0	0	400	3
Recreational specialist	14,200	12,900	0	0	1,300	4
Occupational therapist trainee	28,057	14,440	12,317	0	1,300	6
MAT assistant trainee	28,057	14,440	12,317	0	1,300	6
Educational therapy assistant trainee	22,217	9,600	12,317	0	300	4
Corrective therapy assistant trainee	22,217	9,600	12,317	0	300	4
Pharmacy intern	9,900	9,000	0	0	900	1
Pharmacy assistant trainee	2,700	2,400	0	0	300	1
Food service worker trainee	10,474	9,974	0	0	500	3
Hospital library student	3,550	3,250	0	0	300	1
Physician's assistant trainee	9,100	8,600	0	0	500	1
Chaplain resident	8,400	8,100	0	0	300	1
Chief nurse trainee	16,760	16,560	0	0	200	1
Associate chief nurse, nursing education trainee	16,760	16,560	0	0	200	1
Graduate engineer trainee	11,726	11,526	0	0	200	1
Personnel management specialist trainee	9,378	9,178	0	0	200	1
Laundry superintendent trainee	7,950	7,750	0	0	200	1
Supply management trainee	9,378	9,178	0	0	200	1
Medical administration trainee (assistant chief, MAD trainee)	9,378	9,178	0	0	200	1
Director, voluntary service trainee	9,378	9,178	0	0	200	1
Assistant hospital director trainee	19,496	18,996	0	0	500	1
Total	383,170	290,618	75,352	0	17,200	66

FARGO, N. DAK.

I. FISCAL YEAR 1970

Category of training	Number of trainees	Cooperating institutions
Medical student 1st 2 school years	52	University of North Dakota School of Medicine, Grand Forks, N. Dak.
Psychology student (graduate)	1	University of North Dakota, Grand Forks, N. Dak.
Social work student (baccalaureate)	3	Concordia College, Moorhead, Minn.; Moorhead State College, Moorhead, Minn.
Pharmacy intern	2	North Dakota State University, Fargo, N. Dak.
Pharmacy resident	1	Do.
Pharmacy student	81	Do.
Dietetic student	7	Do.
Food service worker trainee	33	Alexandria Area Vocational Technology School, Alexandria, Minn.
Administrative intern	1	Moorhead State College, Moorhead, Minn.
Graduate engineer trainee	2	
Personnel management specialist trainee	1	
Medical administrative trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

The State of North Dakota has initiated a MEDEX training program for the purpose of training physician assistants. We contemplate becoming involved in the orientation and academic phase of this MEDEX training. No additional funds are presently anticipated.

BRECKSVILLE, OHIO

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Dental assistant trainee	12	Cuyahoga Community College, Cleveland, Ohio.
Dental hygienist trainee	37	Do.
Basic nursing student	114	Do.
Psychology student (graduate)	15	Kent State University, Kent, Ohio; Ohio State University, Columbus, Ohio.
Social work student (master's)	6	Case Western Reserve University, Cleveland, Ohio.
Corrective therapist student	2	Kent State University, Kent, Ohio; Central State University, Wilberforce, Ohio.; University of Dayton, Dayton, Ohio.
Podiatry student	6	Case Western Reserve University, Cleveland, Ohio.
Chief nurse trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Dental assistant trainee	$35,400	$12,000	$3,200	$20,000	$200	28
Dental hygienist trainee	16,400	3,000	3,200	10,000	200	23
Basic nursing student	12,500		12,000		500	120
Social work student	16,700	16,500			200	12
Corrective therapist student	13,500	13,200			300	4
Podiatry student	3,100	3,000			100	6
Personnel management specialist trainee	8,100	8,100				1
Total	105,700	55,800	18,400	30,000	1,500	194
NEW PROGRAMS						
Dental laboratory technician trainee	47,300	30,000	7,000	10,000	300	20
Practical nurse trainee	87,500	75,000	12,000		500	60
Professional nurse trainee	60,200	60,000			200	40
Social work student	46,100	36,000		10,000	100	12
Social work assistant trainee	46,100	36,000	10,000		100	18
Occupational therapist student	39,800	39,600			200	12
Physical therapist student	39,800	39,600			200	12
Dietetic student	12,100	12,000			100	6
X-ray technician trainee	36,500	16,000		20,000	500	20
P.M. & R. coordinator trainee	8,000	8,000				1
Hospital administration resident	12,000	12,000				1
Graduate engineer trainee	9,000	9,000				1
Total	444,400	373,200	29,000	40,000	2,200	203
Grand total	550,100	429,000	47,400	70,000	3,700	397

CHILLICOTHE, OHIO

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Psychology student (graduate)	6	Ohio State University, Columbus, Ohio; Ohio University, Athens, Ohio.
Social work student (master's)	8	Ohio State University, Columbus, Ohio; West Virginia University, Morgantown, W. Va.
Corrective therapist student	1	Ohio University, Athens, Ohio.
Physical medicine and rehabilitation student	16	Muskingum College, New Concord, Ohio.
Graduate nursing student	2	Ohio State University, Columbus, Ohio.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Graduate nursing student	$10,000		$10,000			10
Social work student	12,620	$12,620				4
Corrective therapist student	11,905		11,905			15
Radiologist-therapist student	11,905		11,905			15
Total	46,430	12,620	33,810			44
NEW PROGRAMS						
Basic R.N. student	20,000		20,000			20
LPN student	10,000		10,000			20
Orthopedic therapist student	44,405	32,500	11,905			10
Physical therapist student	11,905		11,905			10
Educational training student	11,905		11,905			10
Total	98,215	32,500	65,715			70
Grand total	144,645	45,120	99,525			114

CINCINNATI, OHIO

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	120	
Medical intern	36	
Career psychiatry resident	3	
Medical student 2d 2 school years	185	University of Cincinnati College of Medicine, Cincinnati, Ohio.
Basic nursing student	132	University of Cincinnati, Cincinnati, Ohio.
Graduate nursing student	30	Do.
Audiology and speech pathology student (master's).	2	Do.
Psychology student (graduate)	13	Do.
Psychology student (postdoctoral)	1	Do.
Vocational rehabilitation counselor student	2	Do.
Social work student (master's)	7	Ohio State University, Cincinnati Center, Cincinnati, Ohio.
Social work student (baccalaureate)	2	University of Cincinnati, Cincinnati, Ohio.
Physical therapist student	14	Indiana University, Indianapolis, Ind.; Ohio State University, Columbus, Ohio; University of Kentucky, Lexington, Ky.
Pharmacy resident	6	University of Cincinnati, Cincinnati, Ohio.
Medical assistant trainee	8	Cincinnati Technical Institute, Cincinnati, Ohio.
Chief nurse trainee	1	
Personnel management specialist trainee	1	
Assistant hospital director trainee	1	

CINCINNATI, OHIO

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
NEW PROGRAMS						
Dental laboratory technician trainee	$24,500	$9,500	$5,000		$10,000	3
Occupational therapy assistant						
Social work assistant	35,392	32,392		$1,500	1,500	4
Physical therapist assistant						1
Manual arts therapist student						1
Pharmacy student	15,500		15,000		500	10
Recreation specialist student						1
Pharmacy assistant	7,500		7,500			4
Dietetic student	1,034	1,304				1
Medical record technician	4,375	4,375				1
Operating room technician	11,706	11,706				2
Urology technician	5,853	5,853				1
Graduate engineer	10,528	10,528				1
Building management officer	8,098	8,098				1
Supply management	8,098	8,098				1
Hospital maintenance workman	94,293	69,888	11,905		12,500	12
Animal caretaker	21,736	16,536	5,200			3
Total	248,883	178,278	44,605	1,500	24,500	47
EXPANDABLE PROGRAMS						
Basic nursing student	9,881		9,881			30
Nursing assistant	72,825	62,544	9,881		400	36
Graduate nursing student	5,000		5,000			10
Audiology and speech path student	9,048	6,548	2,500			1
Social work student (master's)	47,297	32,392	11,905	1,500	1,500	4
Social work student (B.A.)	47,297	32,392	11,905	1,500	1,500	4
Occupational therapist student	15,000	5,200	9,800			4
Physical therapist student	9,800		9,800			2
Pharmacy resident	146,000	120,000	15,000	3,000	8,000	12
Chief nurse	14,192	14,192				1
Hospital administrator resident	6,059	6,059				1
Personnel management specialist	8,098	8,098				1
Total	390,497	287,425	85,672	6,000	11,400	106
Grand total	639,380	465,703	130,277	7,600	35,900	153

CLEVELAND, OHIO

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	100	
Medical intern	7	
Career psychiatry resident	2	
Career radiology resident	1	
Dental intern (noncareer)	2	
Career dental intern	1	
Dental hygienist trainee	28	Cuyahoga Community College, Cleveland, Ohio.
Basic nursing student	62	Cuyahoga Community College, Cleveland, Ohio; St John's College, Cleveland, Ohio.
Audiology and speech pathology student (doctoral).	2	Case Western Reserve University, Cleveland, Ohio.
Psychology student (graduate)	7	Do.
Social work student (doctoral)	1	Do.
Social work student (master's)	18	Cleveland State University, Cleveland, Ohio.
Social work student (baccaluareate)	1	Do.
Physical therapist student	8	Case Western Reserve University, Cleveland, Ohio; Ohio State University, Colubmus, Ohio.
Corrective therapist student	5	Kent State University, Kent, Ohio.
Dietetic intern	13	Case Western Reserve University, Cleveland, Ohio.
Dietetic intern affiliate	6	University Hospitals, Cleveland, Ohio; Mount Sinai Hospital, Cleveland, Ohio.
Dietetic student	1	Cuyahoga Community College, Cleveland, Ohio.
Certified laboratory assistant trainee	4	Do.
Hospital librarian work-study trainee	3	Case Western Reserve University, Cleveland, Ohio.
Prosthetic representative trainee	1	
Research and education trainee	2	Case Western Reserve School of Medicine, Cleveland, Ohio.
Medical administrative trainee	1	
Medical student 1st 2 school years	43	Do.
Medical student 2d 2 school years	41	Do.
Dental student 2d 2 school years	7	Case Western Reserve University, School of Dentistry, Cleveland, Ohio.

CLEVELAND, OHIO

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space (feet)	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Basic nursing	$14,500	0	$13,500	$1,000	0	40
Graduate nursing	0	0	0	0	0	5
Basic instruction for nurse's aide	0	0	0	0	0	20
Social work student	26,420	$19,920	0	500	$6,000	6
Library work study program	6,548	6,548	0	0	0	2
Total	47,468	26,468	13,500	1,500	6,000	73

DAYTON, OHIO

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	61	
Dental intern (noncareer)	1	
Career dental intern	2	
Basic nursing student	30	Kettering College of Medical Arts, Kettering, Ohio.
Psychology student (graduate)	5	University of Cincinnati, Cincinnati, Ohio; Miami University, Oxford, Ohio. Ohio State University, Columbus, Ohio.
Occupational therapist student	1	Western Michigan University, Kalamazoo, Mich.
Physical therapist student	9	University of Kentucky, Lexington, Ky.; Ohio State University, Columbus, Ohio; Loma Linda College, Loma Linda, Calif.
Corrective therapist student	3	University of Dayton, Dayton, Ohio; Central State University, Wilberforce, Ohio.
Inhalation therapy technician trainee	15	Kettering College of Medical Arts, Kettering, Ohio.
Hospital administration resident	1	Xavier University, Cincinnati, Ohio.
Personnel management specialist trainee	2	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Psychology students	$280,028	$280,028			None	73
Total	280,028	280,028				
NEW PROGRAMS						
Dental assistant	21,848	21,848			None	4
Dental lab technician	24,536	24,536			None	4
Basic nursing students					None	50
Audiology and speech pathology	13,464	13,464			None	3
Social work	15,360	15,360			None	4
Pharmacy intern	16,032	16,032			None	2
Pharmacy resident	13,680	13,680			None	2
Engineering trainee	8,856	8,856			None	1
Building management trainee	7,776	7,776			None	1
Supply trainee	8,340	8,340			None	1
Medical administrator trainee	8,460	8,460			None	1
Total	138,352	138,352			None	
Grand total	418,380	418,380			None	146

MUSKOGEE, OKLA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Social work student (master's)	4	University of Oklahoma, Norman, Okla.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

This hospital is involved in allied and administrative health training through the Exchange of Medical Information Program. This includes the training of Physician Assistants, laboratory personnel, Inhalation Therapy Technicians, and proposed training programs for Physical Therapy Assistants and Nurses.

The trainees' salaries or stipends, instructors' salaries, and other costs are paid through the Exchange of Medical Information funds. Additional dollars are needed for space modifications for these training facilities. It is estimated that these space modifications could be completed for approximately $50,000. These will be submitted as nonrecurring M&R projects in the FY 1972 budget.

OKLAHOMA CITY, OKLA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	121	
Medical intern	44	
Career psychiatry resident	2	
Career radiology resident	9	
Career anesthesiology resident	2	
Career pathology resident	1	
Dental resident (noncareer)	7	
Dental intern (noncareer)	3	
Medical student 1st 2 school years	234	University of Oklahoma School of Medicine, Oklahoma City, Okla.
Medical student 2d 2 school years	208	Do.
Basic nursing student	297	University of Oklahoma, Norman, Okla.; Oklahoma Baptist University, Shawnee, Okla.
Audiology and speech pathology student (doctoral).	12	University of Oklahoma, Norman, Okla.
Audiology and speech pathology student (master's).	6	Do.
Psychology student (graduate)	6	Do.
Psychology student (postdoctoral)	2	Do.
Psychology student (baccalaureate)	1	Do.
Social work student (master's)	4	Do.
Physical therapist student	3	Do.
Pharmacy intern	4	
Dietetic intern affiliate	16	University of Oklahoma, Norman, Okla.; Oklahoma State University, Stillwater, Okla.
Medical technologist student	15	University of Oklahoma, Norman, Okla.
Cytotechnologist student	7	Do.
Histologic or histopathology technician trainee	1	
Medical technician trainee	4	Do.
Hospital librarian work-study trainee	1	Do.
Radiologic technologist trainee	39	Do.
Research and education trainee	17	University of Oklahoma School of Medicine, Oklahoma City, Okla.
Gastroenterology technician trainee	2	Do.
Accountant trainee	1	
Building management officer trainee	2	
Supply management trainee	1	

OKLAHOMA CITY, OKLA.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Basic nursing students	$85,442	0	$78,430	$3,500	$3,512	15
Social work student	35,725	$7,680	20,045	8,000	0	2
Physical therapist students	9,206	0	8,956	0	250	1
Pharmacy interns	16,196	16,196	0	0	0	2
Medical technologist student	44,992	17,992	11,000	0	16,000	8
Radiologic technologist trainee	28,800	4,800	24,000	0	0	4
Inhalation therapy technician trainee	19,712	5,212	9,500	0	5,000	1
Total	240,073	51,880	151,931	11,500	24,762	34
NEW PROGRAMS						
Dental assistant trainee	0	0	0	0	0	4
Dental hygienist trainee	0	0	0	0	0	2
Dental laboratory technician	0	0	0	0	0	1
Nursing assistant trainee	13,657	0	13,072	0	585	8
Nursing intern	111,395	70,424	39,215	0	1,756	8
Vocational rehabilitation counselor student	26,666	11,500	14,192	0	974	2
Social work assistant trainee	0	0	0	0	0	2
Occupational therapist student	15,706	6,500	8,956	0	250	2
Rorrective therapist student	9,206	0	8,956	0	250	2
Cecreation specialist student	250	0	0	0	250	1
Occupational therapy assistant trainee	250	0	0	0	250	2
Physical therapy assistant trainee	250	0	0	0	250	2
Manual arts therapy assistant trainee	250	0	0	0	250	1
Corrective therapy assistant trainee	250	0	0	0	250	2
Radioisotope technician trainee	14,400	2,400	12,000	0	0	2
Radiation therapy technologist trainee	16,800	4,800	12,000	0	0	4
Prosthetic representative trainee	7,080	7,080	0	0	0	1
Physician's assistant trainee	56,000	26,000	20,000	0	10,000	5
Electrocardiographic technician trainee	13,212	5,212	5,000	0	3,000	1
Electroencephalograph technician trainee	1,400	1,200	0	0	200	1
Hemodialysis technician trainee	20,212	5,212	10,000	0	5,000	1
Cardiopulmonary technician trainee	20,212	5,212	10,000	0	5,000	1
Veterinary medical resident investigator trainee	34,400	24,000	8,400	0	2,000	2
Extracorporeal perfusion (pump) technician trainee	7,048	6,048	0	0	1,000	1
Surgery technician trainee (general)	7,048	6,048	0	0	1,000	1
Monitoring technician trainee	0	0	0	0	0	2
Operating room technician trainee	7,048	6,048	0	0	0	1
Orthopedic technician trainee	7,048	6,048	0	0	1,000	1
Thoracic surgery technician trainee	7,048	6,048	0	0	1,000	1
Urology technician trainee	7,048	6,048	0	0	1,000	1
Chief nurse trainee	14,192	14,192	0	0	0	1
Personnel management specialist trainee	8,098	8,098	0	0	0	1
Biomedical instrumentation technician trainee	250	0	0	0	250	1
Total	426,424	228,118	161,791	0	36,515	60
Grand total	666,497	279,998	313,722	11,500	61,277	94

PORTLAND, OREG.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	111	
Medical intern	34	
Career neurology resident	1	
Career P.M. & R. resident	3	
Dental intern (noncareer)	3	
Career dental intern	1	
Medical student 1st 2 school years	91	University of Oregon Medical School, Portland, Oreg.
Medical student 2d 2 school years	121	Do.
Basic nursing student	67	University of Oregon, Portland, Oreg.
Audiology and speech pathology student (master's).	3	Portland State University, Portland, Oreg.
Psychology student (graduate)	1	University of Oregon, Portland, Oreg.
Social work student (master's)	5	Portland State University, Portland, Oreg.
Occupational therapist student	2	University of Puget Sound, Tacoma, Wash.
Corrective therapist student	2	Eastern Washington State College, Cheney, Wash.
Occupational therapy assistant trainee	8	Mount Hood Community College, Portland, Oreg.
Physical therapy assistant trainee	14	Do.
Pharmacy intern	6	Oregon State University, Corvallis, Oreg.
Dietetic intern affiliate	11	University of Oregon, Portland, Oreg.
Building management officer trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional or new trainees
EXPANDABLE PROGRAMS						
Graduate nurse	$2,000				$2,000	3
Audiology and speech pathology	4,020	$3,320			700	1
Occupational therapist assistant trainee	3,950	3,250			700	1
Social worker, student	10,960	9,960			1,000	3
Pharmacy intern	9,656	8,956			700	1
Dietetic intern	1,500				1,500	2
Total	32,086	25,486			6,600	11
NEW PROGRAMS						
Practical nurse	11,300		$5,300		6,000	10
Graduate engineer trainee	10,528	10,528				1
Personnel management specialist trainee	8,098	8,098				1
Supply management trainee	8,098	8,098				1
Medical administrative trainee	8,098	8,098				1
Total	46,122	34,822	5,300		6,000	14
Grand total	78,208	60,308	5,300		12,600	25

ROSEBURG, OREG.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	64	Southern Oregon College, Ashland, Oreg.; Lane Community College, Eugene, Oreg.
Practical nurse student	19	Umpqua Community College, Roseburg, Oreg.
Psychology student (graduate)	15	University of Oregon, Department of Psychology, Eugene, Oreg.; University of Oregon, Counseling Department, Eugene, Oreg.
Clinical social science trainee	12	University of Oregon, School of Community Service and Public Affairs, Eugene, Oreg.
Personnel management specialist trainee	1	
Building management officer trainee	1	

ROSEBURG OREG.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Clinical social science trainees	$22,947	$7,821	$15,126			11
Total	22,947	7,821	15,126			11
NEW PROGRAMS						
Nursing assistant trainee	50,666	39,896	10,670		$100	24
Social work student	7,170	7,170				2
MAT student	7,072	7,072				1
CT student	7,072	7,072				1
Recreational specialist student	35,360	35,360				5
Occupational therapy assistant trainee	16,926	16,926				3
Physical therapy assistant trainee	5,642	5,642				1
MAT assistant trainee	16,926	16,926				3
General P.M. & R. assistant trainee	16,926	16,926				3
Pharmacy intern	8,736	8,736				1
Pharmacy student	7,072	7,072				1
Dietetic student	6,318	6,318				1
Food service worker trainee	20,202	20,202				6
Medical technician trainee	5,642	5,642				1
X-ray technician trainee	5,642	5,642				1
Inhalation therapy technician trainee	5,642	5,642				1
EKG technician trainee	5,642	5,642				1
EEG technician trainee	5,642	5,642				1
Surgical technician trainee (general)	5,642	5,642				1
OR technician trainee	5,642	5,642				1
Urology technician trainee	5,642	5,642				1
Personnel management specialist trainee	8,736	8,736				1
Total	259,960	249,190	10,670		100	61
Grand total	282,907	257,011	25,796		100	72

WHITE CITY, OREG.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	30	Southern Oregon College, Ashland Oreg.

ALTOONA, PA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical secretary	2	Altoona School of Commerce, Altoona, Pa.

BUTLER, PA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Dental assistant trainee	2	Median Schools, Pittsburgh, Pa.
Psychology student (graduate)	1	University of Pittsburgh, Pittsburgh, Pa.

BUTLER, PA.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
NEW PROGRAMS						
Dental laboratory technician trainee	$5,853	$5,853				1
Physical therapist student	5,560	5,560				1
Corrective therapist student	3,320	3,320				1
Recreation specialist student	6,000	6,000				1
Pharmacy student	5,853	5,853				1
Dietetic student	5,853	5,853				1
Total	32,439	32,439				6

COATESVILLE, PA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	3	
Career psychiatry resident	3	
Career neurology resident	2	
Medical student (second 2 school years)	65	Jefferson Medical College, Philadelphia, Pa.
Basic nursing student	73	Coatesville Hospital, Coatesville, Pa.; Northeastern Hospital, Philadelphia, Pa.; Community Medical Center, Scranton, Pa.
Psychology student (graduate)	8	Temple University, Philadelphia, Pa.; University of West Virginia, Morgantown, W. Va.; Columbia University, New York, N.Y.
Social work student (master's)	2	University of Pennsylvania, Philadelphia, Pa.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Basic nurse student	$12,000		$12,000			32
Nursing assistant	26,621	$4,621	22,000			125
Social work student	18,130	18,130				6
Social work assistant	18,644	18,644				3
Personnel specialist	6,075	6,075				1
Total	81,470	47,470	34,000			167
NEW PROGRAMS						
Practical nurse	12,000		12,000			50
Professional nurse	12,000		12,000			50
Psychology technician	6,400	6,000			$400	2
Social work student	19,752	5,560	14,192			11
Occupational therapist assistant	43,176	33,195	9,881		100	6
Manual arts therapist assistant	32,161	22,130	9,881		150	4
Corrective therapy assistant	32,161	22,130	9,881		150	4
Medical technician	16,597	6,548	4,049		6,000	1
Autopsy assistant	11,597	6,548	4,049		1,000	1
Medical records technician	5,853	5,853				1
Medical assistant administrator	6,548	6,548				1
Total	198,245	114,512	75,933		7,800	
Grand total	279,715	161,982	109,933		7,800	

ERIE, PA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	2	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructors salaries	Space	Other costs	Number of additional and new trainees
NEW PROCEDURES						
Dental assistant trainee	$5,085	$5,085	0	0	0	1
Basic nursing student (if school provides supervision)	0		0	0	0	10
Practical nurse student	15,990		$14,000	$750	$1,240	10
Nursing assistant trainee	64,820	50,820	14,000			10
Social work student	250		0		250	1
Occupational therapy assistant trainee	5,800	5,800	0			1
Physical therapy assistant trainee	5,800	5,800	0			1
Pharmacy student	0		0			1
Pharmacy assistant trainee	5,800	5,800	0			1
Medical technician trainee	5,085	5,085	0			1
Total	108,630	78,390	28,000	750	1,490	37

LEBANON, PA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	29	York Hospital, York, Pa.
Personnel management specialist trainee	2	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
NEW PROGRAMS						
Professional nurse trainee (refresher)	$160,120	$148,215	$11,905	None	None	15
Nursing assistant trainee	69,315	69,315	None	None	None	15
Social work student (master degree training)	12,000	12,000	None	None	None	2
Physical therapist student (baccalaureate or higher training)	12,000	12,000	None	None	None	2
Food service worker trainee	70,357	61,401	8,956	None	None	12
Total	323,792	302,931	20,861	None	None	46

PHILADELPHIA, PA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical residents (noncareer)	119	
Medical intern	27	
Career radiology resident	1	
Career pathology resident	1	
Dental intern (noncareer)	2	
Career dental intern	1	
Medical student 1st 2 school years	120	University of Pennsylvania School of Medicine, Philadelphia, Pa.; Jefferson Medical College, Philadelphia, Pa.
Medical student 2d 2 school years	255	Do.
Dental assistant trainee	6	Murrell Dobbins Area Vocational Technical School, Philadelphia, Pa.
Dental hygienist trainee	34	University of Pennsylvania School of Dental Medicine, Philadelphia, Pa.
Dental laboratory technician trainee	2	Mastbaum Area Vocational Technician School, Philadelphia, Pa.
Dental student summer research trainee	2	New York University College of Dentistry, New York, N.Y.; University of Pennsylvania School of Dental Medicine, Philadelphia, Pa.
Basic nursing student	273	Community college—Philadelphia, Pa.; Philadelphia General Hospital, Philadelphia, Pa.; St. Agnes Hospital, Philadelphia, Pa.
Graduate nursing student	7	University of Pennsylvania Hospital, Philadelphia, Pa.
Psychology student (graduate)	2	Temple University, Philadelphia, Pa.
Social work student (master's)	2	Graduate School of Social Work, University of Pennsylvania, Philadelphia, Pa.
Occupational therapist student	6	University of Pennsylvania, Philadelphia, Pa.; Temple University, Philadelphia, Pa.
Physical therapist student	11	Do.
Occupational therapy assistant trainee	2	University of Pennsylvania, Philadelphia, Pa.; Chestnut Hill College, Philadelphia, Pa.
Pharmacy student	112	Philadelphia College of Pharmacy and Science, Philadelphia, Pa.
Medical technician trainee	16	Murrell Dobbins Area Vocational Technical School, Philadelphia, Pa.
Radiologic technologist trainee	5	Do.
Research and education trainee	4	University of Pennsylvania School of Dental Medicine, Philadelphia, Pa.; University of Pennsylvania School of Medicine, Philadelphia, Pa.
Medical administrative trainee	1	
Veterinary student	4	University of Pennsylvania School of Veterinary Medicine, Philadelphia, Pa.
Paramedical services orientation	15	Temple University, Philadelphia, Pa.; West Philadelphia, Community Free School, Philadelphia, Pa.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Social work student	$6,310	$6,310	None	None	None	2
Medical technologist trainee	19,174	11,076	None	None	$8,098	12
Medical radiology technician trainee	14,678	7,384	None	None	7,294	8
Total	40,162	24,770			15,392	22
NEW PROGRAMS						
Personnel management specialist trainee	$8,745	8,745	None	None	None	1
Building management trainee (officer)	7,071	7,071	None	None	None	1
Supply management trainee	8,745	8,745	None	None	None	1
Medical administration trainee	8,745	8,745	None	None	None	1
Electrocardiograph technician trainee	2,606	2,606	None	None	None	1
Inhalation therapy technician trainee	31,800	16,000	$9,000	None	6,800	4
Total	67,712	51,912	9,000		6,800	9
Grand total	107,874	76,682	9,000	None	22,192	31

PHILADELPHIA, PA.[1]

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Audiology and speech pathology student (master's).	17	Temple University, Philadelphia, Pa.
Psychology student (graduate)	1	Do.
Social work student (master's)	3	Do.
Social work student (baccalaureate)	1	Do.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space modifications	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Audiology and speech pathology	$27,845	$8,976	$10,869	$8,000		2
NEW PROGRAMS						
Social work	39,030	24,840	14,190			6
Grand total	66,875	33,816	25,059	8,000		8

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[1] Outpatient clinic.

PITTSBURGH, PA., (GENERAL)

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	99	
Medical intern	30	
Career pathology resident	1	
Dental resident (noncareer)	1	
Dental intern (noncareer)	2	
Medical student, 1st 2 school years	30	University of Pittsburgh School of Medicine, Pittsburgh, Pa.
Medical student, 2d 2 school years	48	Do.
Dental assistance trainee	63	University of Pittsburgh and Homewood/Brushton Health Center, Pittsburgh, Pa.
Dental hygienist trainee	53	University of Pittsburgh School of Dentistry, Pittsburgh, Pa.
Dental laboratory technician trainee	1	Do.
Basic nursing student	189	University of Pittsburgh School of Nursing, Pittsburgh, Pa.; Sewickley Valley Hospital, Pittsburgh, Pa.; St. Joseph's Hospital, Pittsburgh, Pa.
Audiology and speech pathology student (doctoral).	4	University of Pittsburgh, Pittsburgh, Pa.
Audiology and speech pathology student (master's).	11	Do.
Psychology student (graduate)	6	Do.
Vocational rehabilitation counselor student	9	Do.
Social work student (master's)	5	Do.
Social work student (baccalaureate)	2	Do.
Occupational therapy assistant trainee	4	Mount Aloysius Junior College, Cresson, Pa.
Pharmacy resident	1	University of Pittsburgh School of Pharmacy, Pittsburgh, Pa.
Hospital librarian work-study trainee	2	University of Pittsburgh Graduate School of Library and Information Sciences, Pittsburgh, Pa.
Inhalation therapy technician trainee	6	Community College of Allegheny County, Pittsburgh, Pa.
Nurse-anesthetist trainee	5	University of Pittsburgh Health Center Hospitals, School for Nurse Anesthetists, Pittsburgh, Pa.
Medical student anesthesiology trainee	1	Jefferson Medical College, Philadelphia, Pa.
Hospital administration resident	2	
Personnel management specialist trainee	3	
Accountant trainee	1	
Building management officer trainee	1	
Management analyst trainee	1	
Director voluntary service trainee	1	
Assistant hospital director trainee	1	
Graduate nursing student	1	University of Pittsburgh School of Nursing, Pittsburgh, Pa.

PITTSBURGH, PA. (GENERAL)

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Dental assistant trainee	$500	0	0	0	$500	2
Dental hygienist trainee	500	0	0	0	500	2
Dental laboratory technician trainee	1,000	0	0	0	1,000	3
Basic nursing student	11,000	0	0	$10,000	1,000	34
Graduate nursing student	12,500	0	$12,000	0	500	9
Audiology and speech pathology student (Ph. D.)	12,500	$12,000	0	0	500	2
Vocational rehabilitation counseling student	10,500	4,000	6,000	0	500	1
Social work student (master's degree training)	8,500	8,000	0	0	500	2
Social work student (baccalaureate training)	500	0	0	0	500	2
Occupational therapy assistant trainee	500	0	0	0	500	2
Pharmacy resident	20,500	20,000	0	0	500	2
Inhalation therapy technician trainee	9,000	0	8,000	0	1,000	6
Personnel management specialist trainee	8,500	8,000	0	0	500	1
Registered nurse hemodialysis trainee	1,000	0	0	0	1,000	5
Total	97,000	52,000	26,000	10,000	9,000	73
NEW PROGRAMS						
Audiology and speech pathology (master's)	5,450	5,200	0	0	250	1
Social work student (Ph. D.)	12,500	12,000	0	0	500	2
Social work student assistant trainee	500	0	0	0	500	2
Food service worker trainee	20,300	0	9,800	10,000	500	20
Medical technology student	51,750	16,250	35,000	0	500	5
Histopathology technician trainee	500	0	0	0	500	1
Medical technician trainee	500	0	0	0	500	5
Medical radiology technician	10,000	0	9,000	0	1,000	5
Electrocardiograph technician trainee	0	0	0	0	0	5
Electroencephalograph technician trainee	0	0	0	0	0	5
Hemodialysis technician trainee	8,500	0	8,000	0	500	4
Operating room technician trainee	8,800	0	8,300	0	500	4
Urology technician trainee	500	0	0	0	500	4
Chief nurse trainee	16,000	15,000	0	0	1,000	1
Associate chief nurse, nurse educational training	16,000	15,000	0	0	1,000	1
Laundry superintendent trainee	8,400	7,900	0	0	500	1
Supply management trainee	8,500	8,000	0	0	500	1
Medical administrative trainee	8,500	8,000	0	0	500	1
Registered nurse diabetes care trainee	12,500	0	10,500	0	2,000	16
Total	189,200	87,350	80,600	10,000	11,250	84
Grand total	286,200	139,350	106,600	20,000	20,250	157

PITTSBURGH, PA. (PSYCHIATRIC)

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Dental resident (noncareer)	3	
Dental intern (noncareer)	2	
Career dental intern	1	
Dental student summer research trainee	2	University of Pittsburgh School of Dentistry, Pittsburgh, Pa.
Basic nursing student	165	Penn State University, Pittsburgh, Pa.; Duquesne University, Pittsburgh, Pa.; Lillian Kaufman School of Nursing, Pittsburgh, Pa.; St. John's General Hospital Pittsburgh, Pa.; St. Margaret Memorial Hospital Pittsburgh, Pa.
Vocational rehabilitation counselor student	5	University of Pittsburgh, Pittsburgh, Pa.
Social work student (master's)	7	University of Pittsburgh, Pittsburgh, Pa.; West Virginia University, Morgantown, W. Va.
Occupational therapist student	5	University of Puerto Rico, San Juan, P.R.
Manual arts therapist student	3	California State College—California, Pa.
Pharmacy intern	1	University of Pittsburgh—Pittsburgh, Pa.
Dietetic intern affiliate	8	Shadyside Hospital—Pittsburgh, Pa.
Research and education trainee	1	University of Pittsburgh—Pittsburgh, Pa.
Dental student 1st 2 school years	18	University of Pittsburgh School of Dentistry—Pittsburgh, Pa.
Psychology student (graduate)	5	University of Pittsburgh—Pittsburgh, Pa.

PITTSBURGH (PSYCHIATRIC)

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Basic nursing student						70
Social work student	$64,238	$46,480	$11,905		$5,853	21
Occupational therapist student	13,000	13,000				4
M.A.T. student						5
Pharmacy intern	16,196	16,196				1
Total	93,434	75,676	11,905		5,853	101
NEW PROGRAMS						
Dental assistant						35
Dental hygienist						35
Pharmacy resident	9,881	9,881				1
Graduate engineer trainee	11,905	11,905				1
Personnel management trainee	6,548	6,548				1
Building management trainee	6,548	6,548				1
Total	34,882	34,882				74
Grand total	128,316	110,558	11,905		5,853	101

WILKES-BARRE, PA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	10	
Dental intern (noncareer)	1	
Basic nursing student	61	College Misericordia, Dallas, Pa.; Wilkes College, Wilkes-Barre, Pa.
Psychology student (graduate)	4	Temple University, Philadelphia, Pa.; Purdue University, Lafayette, Ind.; West Virginia University, Morgantown, W. Va.
Social work student (master's)	7	Marywood College, Scranton, Pa.
Dietetic student	23	Do.
Hospital librarian work-study trainee	2	Do.
Personnel management specialist trainee	2	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Social work student (in masters training)	$6,800	$6,800	None	None	None	2
Hospital librarian (work study trainee)	7,300	7,300	None	None	None	1
Total	14,100	14,100	None	None	None	3
NEW PROGRAMS						
Dental assistant trainee	9,700	(1)	$8,700	None	$1,000	10
Professional nurse trainee	74,444	60,444	14,000	None	None	36
Pharmacy intern	9,600	9,600	None	None	None	1
Dietetic intern	97,000	84,000	13,000	None	None	12
Total	190,744	154,044	35,700	None	1,000	59
Grand total	204,844	168,144	35,700	None	1,000	62

[1] Vocational training.

MANILA, PHILIPPINES

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Number of trainees	Cooperating institutions
Social work student (baccalaureate)	1	University of Santo Tomas—Manila Philippines
Orthotist-prosthetist trainee	1	Veterans Memorial Hospital—Quezon City, Philippines

SAN JUAN, P.R.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	6	
Medical intern	10	
Career P.M. & R. resident	1	
Career dental intern	1	
Medical student 1st 2 school years	80	University of Puerto Rico School of Medicine, Rio Piedras, P.R.
Medical student 2d 2 school years	130	Do.
Dental student 2d 2 school years	31	Do.
Audiology and speech pathology student (doctoral).	1	University of Michigan, Ann Arbor, Mich.
Psychology student (graduate)	6	University of Puerto Rico, Rio Piedras, P.R.
Social work student (master's)	6	Do.
Occupational therapist student	7	Do.
Physical therapist student	18	Do.
Dietetic intern	8	Do.
Dietetic intern affiliate	4	Do.
Medical technologist student	18	Do.
Medical technician trainee	1	Fajardo District Hospital, Fajardo, P.R.
Medical record librarian trainee	7	University of Puerto Rico, Rio Piedras, P.R.
Medical record technician trainee	14	Puerto Rico Jr. College, Rio Piedras, P.R.
Hospital administration resident	5	Do.
Practical nurse student	26	Miguel Such Vocational School, Rio Piedras, P.R.; Tomas Orgay Vocational High School, Rio Piedras, P.R.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Dietetic intern	$16, 800	$2, 800				6
NEW PROGRAMS						
Audiology and speech pathology student	3, 320	3, 320				1
Social work student	6, 640	3, 320				2
Hemodialysis technician trainee	6, 548	6, 548				1
P.M. & R. coordinator trainee	6, 548	6, 548				1
Personnel management specialist trainee	8, 098	8, 098				1
Medical administration trainee	8, 098	8, 098				1
Total	39, 252	35, 932				7
Grand total	56, 052	38, 732				13

PROVIDENCE, R.I.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	29	
Medical intern	11	
Dental assistant trainee	16	Rhode Island Junior College, Providence, R.I.
Basic nursing student	109	Salve Regina College, Newport, R.I., University of Rhode Island, Kingston, R.I.; Roger Williams General Hospital, Providence, R.I.
Psychology student (graduate)	2	University of Rhode Island, Kingston, R.I.
Social work student (master's)	4	Boston University, Boston, Mass.; Boston College, Boston, Mass.; University of Connecticut, Storrs, Conn.
Medical technician trainee	3	Rhode Island Junior College, Providence, R.I.
Medical student 2d 2 school years	4	Loyola University, Stritch School of Medicine, Chicago Ill.; Boston University School, of Medicine, Boston Mass.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAM						
Social work student	$21,865	$9,960	$11,905			3
NEW PROGRAMS						
Pharmacy intern	16,196	16,196				2
Supply management trainee	8,093	8,098				1
Medical administration trainee	8,098	8,098				1
Total	32,393	32,392				4
Grand total	42,352	42,352	11,905			7

CHARLESTON, S.C.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	67	
Medical intern	31	
Career pathology resident	1	
Dental resident (noncareer)	3	
Medical student 2d 2 school years	152	Medical University of South Carolina, Charleston, S.C.
Basic nursing student	65	Baptist College at Charleston, Charleston, S.C.; Medical University of South Carolina, Charleston, S.C.
Psychology student (graduate)	5	University of Florida, Tallahassee, Fla.; University of Georgia, Athens, Ga.; University of South Carolina, Columbia, S.C.
Social work student (master's)	7	University of North Carolina, Chapel Hill, N.C.; University of South Carolina, Columbia, S.C.
Pharmacy student	14	Medical University of South Carolina, Charleston, S.C.
Medical technologist student	11	Do.
Certified laboratory assistant (trainee)	9	Do.
Nurse-anesthetist trainee	13	Do.
Management analyst trainee	1	

CHARLESTON, S.C.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
NEW PROGRAMS						
Pharmacy intern (total)	$8,000	$8,000	None	None	None	1

COLUMBIA, S.C.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	2	
Basic nursing student	29	University of South Carolina, Columbia, S.C.
Audiology and speech pathology student (master's).	4	Do.
Psychology student (graduate)	4	Do.
Social work student (master's)	3	University of Georgia, Athens, Ga.; University of South Carolina, Columbia, S.C.
Social work student (baccalaureate)	2	Columbia College, Columbia, S.C.; Benedict College, Columbia, S.C.
Hospital librarian student	2	Columbia College, Columbia, S.C.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Audiologist and speech pathology (student in masters degree training)	$17,210	$7,210		$8,000	$2,000	2
Social worker student (in master degree training)	18,616	6,640	$10,869	1,082	25	2
Social worker student (baccalaureate training)	0					2
Total	35,826	13,850	10,869	9,082	2,025	6
NEW PROGRAMS						
Medical technologist student (in program approved by AMA council on medical education) (total)	15,679	4,498	9,981		1,200	2
Grand total	51,505	18,348	20,850	9,082	3,225	8

FORT MEADE, S. DAK.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Practical nurse student	22	Black Hills Area Vocational Technical School, Rapid City, S. Dak.
Occupational therapist student	2	University of Kansas, Lawrence, Kans.; Indiana University, Indianapolis, Ind.
Manual arts therapist student	2	Northern State College, Aberdeen, S. Dak.; University of N. Dak. Ellendale Branch, Ellendale, N. Dak.

HOT SPRINGS, S. DAK.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed—Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE AND NEW TRAINING PROGRAMS						
Social worker assistant trainee	$7,312	$5,212	$2,100	0	0	1
Occupational therapy assistant trainee	6,152	4,621	1,531	0	0	1
Physical therapy assistant	6,152	4,621	1,531	0	0	1
Correctional therapy assistant	6,152	4,621	1,531	0	0	1
Pharmacy assistant trainee	6,152	4,621	1,531	0	0	1
Medical technician	6,152	4,621	1,531	0	0	1
General surgery technician	6,152	4,621	1,531	0	0	1
Operating room technician	6,152	4,621	1,531	0	0	1
Graduate engineer trainee	8,098	8,098		0	0	1
Personnel specialist trainee	6,548	6,458		0	0	1
Building management officer trainee	6,548	6,548		0	0	1
Medical supply aide trainee	4,621	4,621		0	0	1
Total	76,191	63,374	12,817	0	0	12

SIOUX FALLS, S. DAK.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	127	University of South Dakota, Vermillion, S. Dak.; Augustana College, Sioux Falls, S. Dak.
Psychology student (graduate)	5	University of South Dakota, Vermillion, S. Dak.; Syracuse University, Syracuse, N.Y.
Social work student (baccalaureate)	1	Augustana College, Sioux Falls, S. Dak.
Occupational therapist student	4	University of North Dakota, Grand Forks, N. Dak.
Personnel management specialist trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training name	Additional dollars needed—Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Occupational therapist student	$23,081	$13,000	$9,881		$200	4
Total	23,081	13,000	9,881		200	4
NEW PROGRAMS						
Professional nurse trainee	70,602	58,352	12,000		250	8
Nursing assistant trainee	43,168	36,968	6,000		200	8
Social work student	36,320	23,920	12,000	$300	100	4
Physical therapist student	6,600	6,500			100	2
Pharmacy intern	8,956	8,956				1
Pharmacy student	16,271	16,196			75	2
Dietetic intern affiliate	29,176	29,176				4
Dietetic resident	42,273	32,392	9,881			4
Personnel management trainee	23,544	14,588	8,956			2
Total	276,910	227,048	48,837	300	725	35
Grand total	299,991	240,048	58,718	300	925	39

MEMPHIS, TENN.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	111	
Medical intern	46	
Career psychiatry resident	2	
Career pathology resident	1	
Dental resident (noncareer)	3	
Dental intern (noncareer)	2	
Career dental resident	1	
Career dental intern	1	
Medical student 1st 2 school years	188	University of Tennessee College of Medicine, Memphis, Tenn.
Medical student 2d 2 school years	102	Do.
Dental student 2d 2 school years	128	University of Tennessee College of Dentistry, Memphis, Tenn.
Dental assistant trainee	9	Memphis Area Vocational School, Memphis, Tenn.
Basic nursing student	149	University of Tennessee College of Nursing, Memphis, Tenn.; Methodist Hospital School of Nursing, Memphis, Tenn.
Professional nurse trainee	28	Memphis City Board of Education, Memphis, Tenn.
Audiology and speech pathology student (master's).	6	Memphis State University, Memphis, Tenn.
Psychology student (graduate)	12	Memphis State University, Memphis, Tenn.; Georgia State University, Atlanta, Ga.; University of Georgia, Athens, Ga.; University of Tennessee, Knoxville, Tenn.; George Peabody College, Nashville, Tenn.; University of South Carolina, Columbia., S.C.
ocial work student (master's)	6	University of Tennessee, Nashville, Tenn.
Occupational therapist student	3	Washington University, St. Louis, Mo.
Physical therapist student	16	University of Tennessee, Memphis, Tenn.
Manual arts therapist student	1	Memphis State University, Memphis, Tenn.
Educational therapist student	4	Harding Graduate School of Religion, Memphis, Tenn.
Corrective therapist student	2	Delta State College, Cleveland, Miss.
Recreation specialist student	1	Memphis State University, Memphis, Tenn.
Occupational therapy assistant trainee	1	Rutherford County Vocational Education, Murfreesboro, Tenn.
Pharmacy resident	2	University of Tennessee, Memphis, Tenn.
Pharmacy student	143	Do.
Medical technologist student	23	Do.
Medical record librarian trainee	50	Baptist Memorial Hospital, Memphis, Tenn.
Chief nurse trainee	1	
Accountant trainee	1	
Supply management trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Occupational therapy student	$17, 750	$7, 200	$10, 000	$300	$250	12
Physical therapy student	10, 800	0	10, 000	800	0	12
Pharmacy resident	31, 536	21, 790	7, 096	2, 500	150	25
Pharmacy student, senior	7, 196	0	7, 096	0	100	25
Inhalation therapy technician trainee	12, 100	3, 000	8, 600	0	500	4
Total	79, 382	31, 990	42, 792	3, 600	1, 000	78
NEW PROGRAMS						
Dental assistant trainee	40, 312	0	22, 200	2, 544	15, 568	12
Audiology and speech Pathology student	14, 600	12, 000	2, 600	0	0	2
Social work student	33, 492	13, 280	15, 000	0	5, 212	6
Pharmacy student, clinical	14, 055	0	11, 905	2, 000	150	50
Dietetic student	12, 554	0	12, 554	0	0	6
Urology technician trainee	14, 400	6, 600	7, 400	0	1, 000	2
Total	129, 413	31, 880	71, 659	4, 544	21, 930	78
Grand total	208, 795	63, 870	114, 451	8, 144	22, 930	156

95

MOUNTAIN HOME, TENN.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	20	East Tennessee State University, Johnson City, Tenn.
Psychology student (graduate)	2	University of Tennessee, Knoxville, Tenn.; University of South Carolina, Columbia, S.C.
Psychology student (baccalaureate)	30	University of Tennessee, Knoxville, Tenn.; East Tennessee State University, Johnson City, Tenn.; Milligan College, Milligan, Tenn.
Social work student (master's)	2	University of Tennesse, Knoxville, Tenn.
Social work student (baccalaureate)	102	East Tennessee State University, Johnson City, Tenn.
Corrective therapist student	1	Do.
Dietetic student	5	Do.
Graduate engineer trainee	2	
Accountant trainee	1	
Supply management trainee	1	
General hospital services orientation	4	State Area Vocational Technical School, Elizabethton, Tenn.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Student nurse						22
Psychology student (baccaluareate)	$8,380		$8,380			75
Social work student (MS)	6,600	$6,000				2
Social work student (baccalaureate)						100
Corrective therapy student						6
Dietetic student (baccaluareate)						5
Supply management trainee	8,098	8,098				1
General hospital Service Orientation (medical secreterial student)						8
Total	22,478	14,098	8,380			219
NEW PROGRAMS						
Dental assistant	6,548		6,548			6
Dental hygienist	7,294		7,294			3
Dental lab technician						3
Practical nurse student	4,000		4,000			10
Professional nurse trainee	13,500	13,500				1
Nursing assistant	12,300		12,300			20
Audio and speech pathology student (MS)						1
Audio and speech pathology student (BS)						1
Vocational rehabilitation counselor student	8,380		8,380			2
Social work assistant trainee						3
MAT student						6
Recreational specialist student	9,881		9,881			8
OT assistant trainee						6
PT assistant trainee						6
MAT assistant						6
CT assistant trainee						6
Pharmacy intern						1
Pharmacy assistant						1
Food Service Worker trainee	9,881		9,881			50
Medical technologist student	19,762		19,762			4
Medical Technician trainee	19,762		19,762			4
Hospital librarian student						2
X-ray technician						1
Inhalation therapy technician trainee	5,940		4,940		$1,000	8
Electrocardiograph technician trainee	10,881		9,881		1,000	8
Cardiopulmonary functionary technical trainee	5,940		4,940		1,000	8
Hospital administrative resident	8,098	8,098				1
Building management officer trainee	8,098	8,098				1
Laundry superintendent						1
Management analyst trainee	9,881	9,881				1
Medical administrative trainee	8,098	8,098				1
Total	168,244	47,675	117,569		3,000	180
Grand total	190,722	61,773	125,949		3,000	399

MURFREESBORO, TENN.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	56	Middle Tennessee State University, Murfreesboro, Tenn.; Columbia State Community College, Columbia, Tenn.
Graduate nursing student	6	Vanderbilt University, Nashville, Tenn.
Psychology student (graduate)	14	George Peabody College, Nashville, Tenn.; Vanderbilt University, Nashville, Tenn.
Social work student (master's)	2	University of Tennessee School of Social Work, Nashville, Tenn.
Corrective therapist student	4	Middle Tennessee State University, Murfreesboro, Tenn.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Basic nursing student	$88	0				25
Graduate nursing student	6	0				6
Social work student	2	$18,920		0	0	6
Manual arts therapist student	0	0	0	0	0	4
Corrective therapist student	0	0	0	0	0	4
Occupational therapy assistant trainee	0	0	0	0	0	4
Total	96	18,920	(1)	(1)	(1)	49
NEW PROGRAMS						
Dental assistant trainee		0	0	0	0	1
Dental laboratory technician trainee		0	0	0	0	1
Nursing assistant trainee						10
Nursing intern						2
Nursing resident						2
Occupational therapist student		0	0	0	0	0
Physical therapist student		0	0	0	0	4
Recreation specialist student		0	0	0	0	4
P.T. assistant trainee		0	0	0	0	4
M.A.T. assistant trainee		0	0	0	0	4
Corrective therapy assistant trainee		0	0	0	0	4
General P.M. &.R. assistant trainee		0	0	0	0	5
Hospital librarian student		0	0	0	0	1
Personnel management specialist trainee		8,098	0	0	0	1
Accountant trainee		8,098	0	0	0	1
Laundry superintendent trainee		5,900	0	0	0	1
Supply management trainee		8,098	0	0	0	1
Total		30,194				46
Grand total		49,114				95

NASHVILLE, TENN.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	136	
Medical intern	46	
Dental resident (noncareer)	1	
Dental intern (noncareer)	6	
Medical student 1st 2 school years	60	Vanderbilt University School of Medicine, Nashville, Tenn.; Meharry Medical College, Nashville, Tenn.
Medical student 2d 2 school years	116	Do.
Dental student summer research trainee	1	Meharry Medical College School of Dentistry, Nashville, Tenn.
Basic nursing student	184	Vanderbilt University School of Nursing, Nashville, Tenn.; Tennessee State University, Nashville, Tenn.; Southern Missionary College, Madison, Tenn.
Nursing intern	2	Vanderbilt University School of Nursing, Nashville, Tenn.
Psychology student (graduate)	2	Vanderbilt University, Nashville, Tenn.; George Peabody College, Nashville, Tenn.
Social work student (master's)	19	University of Tennessee School of Social Work, Nashville, Tenn.
Pharmacy intern	2	Vanderbilt University, Nashville, Tenn.
Dietetic intern affiliate	15	Do.
Food service worker trainee	2	
Medical technologist student	28	Tennessee State University, Nashville, Tenn.; David Lipscomb College, Nashville, Tenn.; George Peabody College, Nashville, Tenn.; Vanderbilt University, Nashville, Tenn.; Tennessee Technical, Cookeville, Tenn.; Middle Tennessee State, Murfreesboro, Tenn.; Western Kentucky University, Bowling Green, Ky.
Cytotechnologist student	1	
Medical technician trainee	8	University of Tennessee, Nashville, Tenn.
Hospital librarian work-study trainee	2	George Peabody College, Nashville, Tenn.
Radiologic technologist trainee	65	Vanderbilt University (hospital), Nashville, Tenn.
Inhalation therapy technician trainee	7	
Nuclear medicine technician trainee	3	Do.
Research and education trainee	3	Vanderbilt University School of Medicine, Nasnville, Tenn.
Associate chief nurse, nursing education, trainee.	1	
Personnel management specialist trainee	1	
Assistant hospital director trainee	1	
Graduate nursing student	6	Vanderbilt University School of Nursing, Nashville, Tenn.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Medical technology training program	$21,400	$9,000	$9,000	$2,500	$900	4
Cytotechnology training program	9,000		9,000			2
Dietetic intern training program	5,540	5,540				2
Library work study program	20,096	13,096	4,500	2,500		2
Hospital pharmacy internship	16,196	16,196				2
Medical radiology technician training program	12,000		10,000		2,000	
Social worker training program	84,500	32,000	33,000	12,500	7,000	10
Nurse internship program	66,900	59,400		5,000	2,500	10
Nuclear medical technician training program	20,200	3,700	10,000	5,500	1,000	3
Total	255,832	138,932	75,500	28,000	13,400	33
NEW PROGRAMS						
Pathology technician training program	13,500	12,000			1,500	3
Physician assistant program	112,000	72,000	25,000	12,000	3,000	6
Total	125,500	84,000	25,000	12,000	4,500	9
Grand total	381,332	222,932	100,500	40,000	17,900	42

AMARILLO, TEX.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Dental assistant trainee	3	Amarillo College School of Bio-Medical Arts & Sciences, Amarillo, Tex.
Basic nursing student	45	Northwest Texas Hospital School of Nursing, Amarillo, Tex.
Radiologic technologist trainee	4	Amarillo College School of Bio-Medical Arts & Sciences, Amarillo, Tex.
Medical record technician trainee	1	Do.

DALLAS, TEX.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	72	
Medical intern	15	
Career psychiatry resident	1	
Career radiology resident	5	
Dental resident (noncareer)	2	
Medical student 2d 2 school years	125	University of Texas Southwestern Medical School, Dallas, Tex.
Dental assistant trainee	8	Dallas County Junior College, Dallas, Tex.
Dental hygienist trainee	40	Baylor University, Dallas, Tex.
Basic nursing student	145	Baylor University, Dallas, Tex.; Dallas Baptist College, Dallas, Tex.; Texas Women's University, Denton, Tex.
Graduate nursing student	6	Texas Women's University, Denton, Tex.
Audiology and speech pathology student (doctoral).	1	Southern Methodist University, Dallas, Tex.
Audiology and speech pathology student (master's).	11	North Texas State University, Denton, Tex.; Southern Methodist University, Dallas, Tex.
Psychology student (graduate)	3	Texas Technological, Lubbock, Tex; University of Texas, Austin, Tex.
Social work student (master's)	2	University of Texas at Arlington, Arlington, Tex.
Graduate engineer trainee	1	
Medical administrative trainee	1	

DALLAS, TEX.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Dental lab technician	$17,136	$15,636			$1,500	3
Audio and speech pathology student	30,283	6,640	$10,869	$1,000	11,774	2
Social work student	3,320	3,320				4
Food service worker trainee	23,712	23,712				10
Total	74,451	49,308	10,869	1,000	13,274	19
NEW PROGRAMS						
Dental student summer resident trainee	900	800			100	1
Radioisotope technician trainee	5,853	5,853				1
X-ray film processor trainee	4,775	4,775				1
Orthotist-prosthetist trainee	6,548	6,548				1
Electrocardiograph technician trainee	5,212	5,212				1
Cardiopulmonary technician trainee	6,548	6,548				1
Accountant trainee	8,098	8,098				1
Building management officer trainee	8,598	8,098			500	1
Laundry superintendent trainee	8,500	8,000			500	1
Total	55,032	53,932			1,100	9
Grand total	129,483	103,240	10,869	1,000	14,470	23

HOUSTON, TEX.

I. FISCAL YEAR 1970

Training programs	Number of trainees	Cooperating institutions
Medical resident (noncareer)	185	
Medical intern	7	
Career neurology resident	13	
Career P.M. & R. resident	7	
Career radiology resident	2	
Career dental resident	7	
Career dental intern	3	
Medical student 1st 2 school years	183	Baylor College of Medicine, Houston, Tex.
Medical student 2d 2 school years	176	Do.
Dental student 1st 2 school years	199	University of Texas Dental Branch, Houston, Tex.
Dental student 2d 2 school years	187	Do.
Dental assistant trainee	7	University of Texas, Houston, Tex.
Dental hygienist trainee	8	Do.
Basic nursing student	425	Texas Women's University, Denton, Tex.; Hermen Hospital School of Nursing, Houston, Tex.; Prairie View A. & M., Prairie View, Tex.; Dominican College, Houston, Tex.; San Jacinto Junior College, Pasadena, Tex.
Graduate nursing student	16	Texas Women's University, Denton, Tex.
Audiology and speech pathology student (master's).	3	University of Houston, Houston, Tex.
Pathology student (graduate)	4	Baylor University, Waco, Tex.
Social work student (master's)	8	Worden College, San Antonio, Tex.; Louisiana State University, Baton Rouge, La.; University of Houston, Houston, Tex.
Social work assistant trainee	12	University of Houston, Houston, Tex.
Occupational therapist student	22	Texas Women's University, Denton, Tex.; Colorado State University, Fort Collins, Colo.; University of Florida, Gainesville, Fla.; University of Kansas, Lawrence, Kans.; Indiana University, Indianapolis, Ind.; Eastern Michigan University, Ypsilanti, Mich.; College of St. Catherine, St. Paul, Minn.; University of Puerto Rico, San Juan, P.R.
Physical therapist student	14	University of Texas, Houston, Tex.; Texas Women's University, Denton, Tex.
Corrective therapist student	8	Texas A. & M. University, College Station, Tex.
Pharmacy resident	4	University of Houston College of Pharmacy, Houston, Tex.
Dietetic intern	17	
Medical technologist student	8	
Inhalation therapy technician trainee	2	South Texas Junior College, Houston, Tex.
Nurse-anesthetist trainee	4	
Medical student anesthesiology trainee	1	Baylor College of Medicine, Houston, Tex.
Chaplain resident	5	Institute of Religion, Houston, Tex.
Personnel management specialist trainee	1	
Building management officer trainee	3	
Supply management trainee	1	
Research and clinical assistant	38	

HOUSTON, TEX.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Dental assistant	$30		$13,532	$79,200	$48,000	22
Basic nursing student	450		0	0	0	18
Audio and speech pathology student		$7,780	0	0	0	2
Social work student (M.A.)	16	37,674	16,084	32,400	4,800	9
Social work student (baccalaureate)	6		0	0	0	2
Pharmacy resident	7	43,476	18,996	42,000	2,800	4
Dietetic intern	36	152,174	26,478	54,000	0	21
Medical technician student	10	4,498	0	0	0	2
Physician's assistant trainee	2	8,098	0	0	0	1
Nuclear medical technician trainee	2	5,558	0	0	0	1
Chaplain resident	6	16,328	0	24,000	0	4
Total	569	275,586	75,090	231,600	55,600	86
NEW PROGRAMS						
Dental hygienist	1		0	0	0	1
Dental laboratory technician	6	31,272	11,197	21,600	9,700	6
Graduate nursing student	35	318,045	28,384	0	0	35
Practical nursing student	20	104,240	0	0	0	20
Professional nurse trainee	20	170,180	28,384	0	0	20
Nursing assistant	20	92,420	0	0	0	20
Social work assistant trainee	8	36,968	13,493	0	1,600	8
Physical therapy	24		11,197	27,340	8,350	24
Manual arts therapy	10		11,197	19,000	7,400	10
Educational therapy	8		11,197	13,000	8,700	8
Corrective therapy	18		22,394	21,000	3,900	18
Recreation specialist trainee	6		0	0	0	6
Occupational therapy assistant trainee	12	62,544	0	0	0	12
Physical therapy assistant trainee	8	41,696	11,197	0	0	8
Manual arts therapy assistant trainee		41,696	0	0	0	8
Educational therapy assistant trainee	4	20,848	0	0	4,700	4
Corrective therapy assistant trainee	4	20,848	0	0	0	4
General P.M. & R. therapy assistant trainee	4	20,848	0	0	0	4
X-Ray technician trainee	7	36,484	11,197	0	0	7
Radiation therapy trainee	1	5,212	0	0	0	1
Inhalation therapy technician trainee	8	41,696	11,197	0	3,200	8
Electroencephalograph technician trainee	1	5,212	0	0	0	1
Cardiopulmonary function technician trainee	4	20,848	9,178	0	0	4
Nuclear medical technician	4	20,848	11,197	0	3,200	4
Operating room technician	4	18,484	0	0	0	4
Ophthalmology technician	2	10,424	0	0	0	2
Orthopedics technician	2	10,424	0	0	0	2
Urology technician	2	10,424	0	0	0	2
P.M. & R. coordinator trainee	4	32,392	0	1,600	4,200	4
Alcoholism counselors	2	13,096	0	0	0	2
Pharmacy student	8		8,996	6,400	8,400	8
Total	265	1,187,149	200,405	109,940	63,350	265
Grand total	834	1,462,735	275,495	341,540	118,950	351

KERRVILLE, TEX.

I. FISCAL YEAR 1970

Training program	Number of training	Cooperating institutions
Medical resident (noncareer)	2	
Psychology student (graduate)	1	Texas Technological University, Lubbock, Tex.
Social work student (master's)	1	Worden School of Social Service, Our Lady of the Lake College, San Antonio, Tex.

KERRVILLE, TEX.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Social weekly service	$1	$3,392				

SAN ANTONIO, TEX.[1]

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Social work student (master's)	4	Our Lady of the Lake College, Worden School of Social Service, San Antonio, Tex.

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[1] Outpatient clinic.

TEMPLE, TEX.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	10	
Psychology student (graduate)	12	Texas Tech. University, Lubbock, Tex. University of Texas, Austin, Tex.
Social work student (master's)	1	Our Lady of the Lake College, San Antonio, Tex.
Social work student (baccalaureate)	8	Prairie View A. & M. College, Prairie View, Tex. Huston-Tillotson College, Austin, Tex.
Occupational therapist student	6	Texas Woman's University, Denton, Tex.
Corrective therapist student	3	University of Texas, Austin, Tex. Huston-Tillotson College, Austin, Tex.
Certified laboratory assistant trainee	8	
Associate chief nurse, nursing education, trainee	1	
Personnel management specialist trainee	1	
Accountant trainee	1	

TEMPLE, TEX

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Occupational therapist student	$500	0	0	0	$500	2
Certified laboratory assistant trainee	16,120	$7,620	0	$8,000	500	6
Social work student	7,140	6,640	0	0	500	2
Total	23,760	14,260	0	8,000	1,500	10
NEW PROGRAMS						
Dental assistant	500	0	0	0	500	2
Dental laboratory technician trainee	11,000	0	0	8,000	3,000	2
Basic nursing student	11,881	0	$9,881	0	2,000	20
Graduate nursing student	0	0	0	0	0	4
Physical therapist student	23,881	13,000	9,881	0	1,000	4
X-ray technician trainee	1,000	0	0	0	1,000	2
Hospital librarian student	8,098	0	8,098	0	0	1
Medical secretary trainee	2,860	0	0	0	2,860	4
Food service manager trainee	11,881	0	9,881	0	2,000	6
Total	71,101	13,000	37,741	8,000	12,360	45
Grand total	94,861	27,260	37,741	16,000	13,860	55

WACO, TEX.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Psychology student (graduate)	4	University of Texas, Austin, Tex.; Texas Technical University, Lubbock, Tex.
Social work student (master's)	9	University of Texas, Austin, Tex.; Worden School of Social Work, Our Lady of the Lake College, San Antonio, Tex.
Occupational therapist student	9	Texas Women's University, Deton, Tex.
Associate chief nurse, nursing education, trainee	1	
Basic nursing student	81	Central Texas Junior College, Waco, Tex.; McLennan Community College, Waco, Tex.; Hilcrest Memorial Hospital, Waco, Tex.; Scott-White Hospital, Waco, Tex.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Field instruction graduate social work student	$31,825	$19,920	$11,905	....	$6,000	6
Total	31,825	19,920	11,905	....	6,000	6
NEW PROGRAMS						
Field instruction undergraduate social work	6,000	6,000	....	....	....	6
Mental hygiene associate	86,280	63,338	15,000	....	7,942	10
Total	92,280	69,338	15,000	....	7,942	16
Grand total	124,101	89,258	26,905	....	13,942	22

SALT LAKE CITY, UTAH

I. FISCAL YEAR 1970

Category of training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	75	
Medical intern	41	
Career anesthesiology resident	3	
Career pathology resident	1	
Medical student 2d 2 school years	104	University of Utah College of Medicine, Salt Lake City, Utah.
Dental hygienist trainee	15	Rangely College, Rangely, Colo.
Basic nursing student	76	University of Utah, Salt Lake City, Utah; St. Marks' School of Nursing, Salt Lake City, Utah.
Practical nurse student	87	Utah Technical College, Salt Lake City, Utah.
Audiology and speech pathology student (master's).	8	University of Utah, Salt Lake City, Utah.
Psychology student (graduate)	17	Do.
Social work student (master's)	13	Do.
Social work student (baccalaureate)	25	Do.
Corrective therapist student	4	Do.
Recreation specialist student	4	Do.
Pharmacy assistant trainee	1	Do.
Medical technician trainee	5	
X-ray technician trainee	2	
Research and education trainee	3	University of Utah, Salt Lake City, Utah.
Graduate engineer trainee	1	
Personnel management specialist trainee	1	
Accountant trainee	1	
Assistant hospital director	1	
Graduate nursing student	2	University of Utah, Salt Lake City, Utah.
Medical assistant	2	Salt Lake Medical and Dental Assistant School, Salt Lake City, Utah.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Master's	$14, 192	None	$14, 192	None	None	None
Baccalaureate	14, 192	None	14, 192	None	None	12
Total	28, 389		28, 384			12
NEW PROGRAMS						
Pharmacy intern	8, 248	$8, 098	150	None	None	1
Total	8, 248	8, 098	150			1
Grand total	36, 632	8, 098	28, 534			13

Note.— We have need and believe can justify a social work educator for an undergraduate training program and one for a graduate training program. Both positions have been formally requested in mid-January 1970. We are currently providing a training experience for 10 graduate students. We are also currently training 3 undergraduate students from 4 colleges or universities in Utah. We have written agreements for both forms of training with each university. The graduate school of social work and the undergraduate training programs are continuing to expand and would like to involve us more than we are currently involved. We are in an excellent position to offer outstanding training to graduate and undergraduate students. In order to expand in these 2 areas, we need funding for 2 social work educator positions.

WHITE RIVER JUNCTION, VT.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	37	
Medical intern	24	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
NEW PROGRAMS						
Medical technician trainee	$6,321	$6,321	0	0	0	1
Autopsy assistant trainee	5,629	5,629	0	0	0	1
Hospital librarian work study trainee	7,072	7,072	0	0	0	1
Nurse anesthesiology trainee	9,200	9,200	0	0	0	1
EKG technician trainee	6,321	6,321	0	0	0	1
Cardio-pulmonary technician trainee	6,321	6,321	0	0	0	1
General surgical technician trainee	6,321	6,321	0	0	0	1
Operating room technician trainee	6,321	6,321	0	0	0	1
Graduate engineer trainee	8,746	8,746	0	0	0	1
Accounting trainee	7,072	7,072	0	0	0	1
Building management officer trainee	8,746	8,746	0	0	0	1
Management analysis trainee	8,746	8,746	0	0	0	1
Supply management trainee	8,746	8,746	0	0	0	1
Medical administration assistant trainee	6,321	6,321	0	0	0	1
Medical supply aide trainee	5,629	5,629	0	0	0	1
Total	107,512	107,512	0	0	0	15

HAMPTON, VA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	6	
Basic nursing student	20	Hampton Institute, Hampton, Va.
Practical nurse student	25	OEO.
Audiology and speech pathology student (master's).	1	Old Dominion University, Norfolk, Va.
Audiology and speech pathology student (baccalaureate).	9	Hampton Institute, Hampton, Va.
Psychology student (master's)	2	University of Texas, Austin, Tex.; Emory University, Atlanta, Ga.
Social work student (master's)	6	Virginia Commonwealth University, Richmond, Va.
Corrective therapy student	11	Hampton Institute, Hampton, Va.; Old Dominion University, Norfolk, Va.; Virginia State College, Norfolk, Va.

105

RICHMOND, VA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	107	
Medical intern	48	
Career P.M. & R. resident	1	
Dental intern (noncareer)	1	
Medical student (first 2 school years)	54	Medical College of Virginia, Richmond, Va.
Medical student (second 2 school years)	119	Do.
Dental student (second 2 school years)	72	Medical College of Virginia School of Dentistry, Richmond, Va.
Basic nursing student	130	John Tyler Community College, Chester, Va.; Grace Hospital, Richmond, Va.; Johnston-Willis Hospital, Richmond, Va.; Richard Memorial Hospital, Richmond Va.; Stuart Circle Hospital, Richmond, Va.
Professional nurse trainee	167	Richmond Area Heart Association, Richmond, Va.
Audiology and speech pathology student (baccalaureate).	3	University of Virginia, Charlottesville, Va.
Social work student (master's)	2	Virginia Commonwealth University School of So Work, Richmond, Va.
Occupational therapist student	11	College of St. Catherine, St. Paul, Minn.; Columbia University, New York, N.Y.; University of Puget Sound, Tacoma, Wash.; Eastern Michigan University, Ypsilanti, Mich.; Virginia Commonwealth University School of Occupational Therapy, Richmond, Va.; University of Wisconsin, Madison, Wis.
Physical therapist student	9	Vrginia Commonwealth University School of Physical Therapy, Richmond, Va.
Recreation specialist student	4	Virginia Commonwealth University School of Recreation, Richmond, Va.; Virginia State College, Petersburg, Va.
Prosthetic representative trainee	1	
Hospital administration resident	1	Virginia Commonwealth University School of Hospital Administration, Richmond, Va.
Accountant trainee	1	
Medical administrative trainee	2	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Audio-speech pathology	$15,000	$15,000	0	0	0	3
Social work student	36,792	16,600	$14,192	$5,000	$1,000	5
Occupational therapy student	3,500	3,500	0	0	0	5
Orthotist-prosthetist trainee	10,424	10,424	0	0	0	2
Prosthetic representative trainee	7,794	7,294	0	0	500	1
Total	73.510	52,818	14,192	5,000	1,500	16
NEW PROGRAMS						
Inhalation therapy technician trainee	10,424	10,424	0	0	0	2
Electrocardiograph technician trainee	10,424	10,424	0	0	0	2
Hemodialysis technician trainee	5,212	5,212	0	0	0	1
Cardiopulmonary technician trainee	5,212	5,212	0	0	0	1
Management analyst trainee	9,881	9,881	0	0	0	1
Total	41,153	41,153	0	0	0	7
Grand total	114,663	93,971	14,192	5,000	1,500	23

SALEM, VA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	17	
Dental assistant trainee	13	Virginia Western Community College, Roanoke, Va.
Basic nursing student	50	Roanoke Memorial Hospital, Inc., Roanoke, Va.; Community Hospital of Roanoke Valley, Roanoke, Va.
Psychology student (graduate)	4	University of West Virginia, Morgantown, W. Va.; University of North Carolina, Chapel Hill, N.C.
Psychology student (postdoctoral)	1	Pennsylvania State University, State College, Pa.
Social work student (master's)	6	University of North Carolina, Chapel Hill, N.C.; Virginia Commonwealth University, Richmond, Va.
Occupational therapist student	4	University of Puerto Rico, Rio Piedras, P.R.; University of New York at Buffalo, Buffalo, N.Y.; University of Florida, Gainesville, Fla.
Chief-of-staff trainee	1	
Building management officer trainee	1	
General hospital services orientation	1	Jefferson High School, Roanoke, Va.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
Basic nursing student	$13,905		$11,905	$2,000		10
Practical nurse student	11,905		11,905			10
Nursing assistant trainee	58,115	$46,210	11,905			20
Social work student (masters)	47,105	33,200	11,905	1,000	$1,200	10
Occupational therapy student	9,500	9,000			500	3
Building management officer trainee	8,098	8,098				1
Total	148,628	96,508	47,620	3,000	1,700	54
NEW PROGRAMS						
Professional nurse refresher						4
Psychology student (BS)	4,000	2,000			800	4
Social work student (BS)	13,105		11,905	600	600	6
Social work assistant (holder of BS)	34,192	26,192		400	400	4
Physical therapist	500				500	10
Corrective therapist	500				500	8
Recreation specialist	500				500	8
General PMR assistant trainee	17,640	17,340			300	3
Pharmacy intern	26,403	16,022	9,881		500	2
Pharmacy student						2
Pharmacy assistant	9,242	9,242				2
Dietetic intern (AFL)	8,212		5,212		3,000	2
Dietetic student	10,424	10,424				2
FSW trainee	30,514	12,729	17,785			6
Medical technician trainee	5,900	4,000	600		1,300	6
X-ray film processor	4,600	4,600				2
Surgical technical trainee	5,853	5,853				1
O.R. Technician trainee	5,212	5,212				1
Administrator intern	21,938	10,869			200	2
Personnel management specialist	8,298	8,098			200	1
Accounting trainee	6,748	6,548			200	1
Laundry superintendent trainee	7,200	7,200				1
Management analyst trainee	8,298	8,098			200	1
Supply management trainee	8,098	8,098				1
Medical administrator trainee	8,298	8,098			200	1
Director VAVS	8,098	8,098			200	1
Total	253,774	178,721	45,383	1,000	9,600	82
Grand total	402,402	275,229	93,003	4,000	11,300	136

AMERICAN LAKE, WASH.

I. FISCAL YEAR 1970

Training name	Number of trainees	Cooperating institutions
Basic nursing student	159	St. Joseph's Hospital, Tacoma, Wash; Highline Junior College, Seattle, Wash.; Pacific Lutheran University, Tacoma.
Psychology student (graduate)	10	University of Washington, Seattle, Wash.; University of Oregon, Corvallis, Oreg.; Washington State University, Pullman, Wash.
Social work student (master's)	2	University of Washington, Seattle, Wash.
Occupational therapist student	5	University of Puget Sound, Tacoma; University of Washington, Seattle, Wash.; University of Wisconsin, Madison, Wis.
Food service worker trainee	1	Washington State Employment Service, Tacoma.
Medical technician trainee	6	Clover Park Vocational Technical School, Tacoma, Wash.
Personnel management specialist trainee	2	
General hospital services orientation	5	Pacific Lutheran University, Tacoma.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
NEW PROGRAMS						
Dental assistant	$5,200	$5,200	0	0	0	2
Dental hygiene	154,000	0	$28,000	$25,000	$101,000	10
Pharmacy assistant	5,200	5,200	0	0	0	2
Library student	5,200	5,200	0	0	0	2
Graduate engineer	8,098	8,098	0	0	0	1
Personnel management specialist	6,500	6,500	0	0	0	1
Supply management trainee	6,500	6,500	0	0	0	1
Medical administrative trainee	6,500	6,500	0	0	0	1
Total	197,198	43,198	28,000	25,000	101,000	20

SEATTLE, WASH.

I. FISCAL YEAR 1970

Category of training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	142	
Medical intern	17	
Career psychiatry resident	1	
Career pathology resident	3	
Dental resident (noncareer)	4	
Dental intern (noncareer)	1	
Career dental intern	1	
Medical student 2d 2 school years	143	University of Washington School of Medicine, Seattle, Wash.
Dental assistant trainee	12	Edmonds Community College, Edmonds, Wash.
Dental hygienist trainee	25	Shoreline Community College, Seattle, Wash.
Basic nursing student	226	University of Washington, Seattle, Wash.; Bellevue Community College, Bellevue, Wash.; Seattle University, Seattle, Wash.
Graduate nursing student	5	University of Washington, Seattle, Wash.
Audiology and speech pathology student (doctoral).	9	Do.
Audiology and speech pathology student (master's).	2	Do.
Psychology student (graduate)	10	University of Oregon, Eugene, Oreg.; University of Washington, Seattle, Wash.; Washington State University, Pullman, Wash.
Psychology student (postdoctoral)	2	Florida State University, Tallahassee, Fla.
Vocational rehabilitation counselor student	4	Michigan State University, East Lansing, Mich.; University of Washington, Seattle, Wash.

SEATTLE, WASH.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Social work student (master's)	8	University of Washington, Seattle, Wash.
Occupational therapist student	22	University of Washington, Seattle, Wash.; University of Puget Sound, Tacoma, Wash.
Physical therapist student	22	University of Washington, Seattle, Wash.
Occupational therapy assistant trainee	2	Green River Community College, Auburn, Wash.
Pharmacy resident	1	University of Washington, Seattle, Wash.
Pharmacy student	4	Do.
Medical technologist student	3	Do.
Medical record librarian trainee	2	Providence Hospital School of Medical Records Science, Seattle, Wash.
Inhalation therapy technician trainee	6	Highline Community College, Midway, Wash.
Electroencephalograph technician trainee	2	University of Washington, Seattle, Wash.
Research and education trainee	2	University of Washington School of Medicine, Seattle, Wash.
Gastroenterology technician trainee	2	
Assistant hospital director trainee	1	
Biomedical photographer	3	Bellevue Community College, Bellevue, Wash.
Central service technician	9	Highline Community College, Midway, Wash.
Metabolic technician	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Dental assistants	$7,920	0	$7,920	0	0	12
Audiology and speech Pathology (doctoral or postdoctroal)	52,400	$22,000	15,400	------------	$15,000	4
Social work students (master's degree)	68,980	43,160	22,520	0	3,300	13
Occupational therapy	17,670	6,500	10,670	0	500	8
Physical therapist	21,540	0	21,340	0	200	8
Occupational therapy assistant	10,240	0	9,670	0	570	8
Pharmacy resident	33,030	22,560	6,470	------------	4,000	3
Pharmacy student	6,470	0	6,470	------------	0	4
Medical technologist	12,970	0	10,820	------------	2,150	6
Inhalation therapy technician	14,210	0	9,710	0	4,500	10
Electroencephalograph technician	48,910	27,250	15,000	0	6,660	7
Gastroenterology technician	6,407	6,007	0	0	400	1
Biomedical photographer	16,550	3,150	10,300	0	3,100	3
Total	317,297	130,627	146,290	0	40,380	87
NEW PROGRAMS						
Aural rehabilitation specialists	39,500	11,000	15,400	0	13,100	2
Bioelectronic communications technician	34,200	12,000	0	------------	22,200	2
Communications disorders management assistants	23,060	0	21,760	0	1,300	16
Electron microscopy technician	16,690	9,280	5,410	0	2,000	2
Dietetic interns	20,480	5,280	14,700	0	500	16
Housekeeping aide trainee	11,150	0	10,150	------------	1,000	42
Intensive coronary care training for nurses	33,650	0	22,450	0	11,200	36
Laboratory aide	31,610	24,000	5,410	------------	2,200	6
Refresher course for medical technologists	5,410	0	5,410	------------		8
Orthopedic assistant	53,504	25,284	18,420	0	9,800	4
Histologic or histopathologic technician	26,350	18,440	5,410	------------	2,500	3
Radiology technician	24,730	0	24,230	0	500	2
Renal dialysis technicians and nurses	198,410	50,000	70,410	------------	78,000	60
Total (new)	518,744	155,284	219,160	------------	144,300	199
Grand total	836,041	285,911	365,450	------------	184,680	286

SPOLANE, WASH.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	31	Washington State University, Pullman, Wash.
Social work student (master's)	2	University of Washington, Seattle, Wash.
Cardiopulmonary technician trainee	3	Spokane Community College, Spokane, Wash.
Personnel management specialist trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Basic nursing student (baccalaureate) nursing assistant	$13, 110	None	$13, 110			8
Trainee						10
Total	13, 110		13, 110	None		18
NEW PROGRAMS						
Dental hygienist trainee	61, 191	None	10, 658	$18, 506	$32, 027	20
Pharmacy student		None	None	None	None	1
Chief nurse trainee	15, 248	$15, 248				1
Administrative intern	7, 299	7, 299	None	None	None	1
Accountant trainee	8, 956	8, 956	None	None	None	1
Total	92, 694	31, 503	10, 658	18, 506	32, 027	24
Grand total	105, 804	31, 503	23, 768	18, 506	32, 027	42

VANCOUVER, WASH.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Dental hygienist trainees	20	Clark College, Vancouver, Wash.
Basic nursing student	11	Do.
Psychology student (graduate)	5	University of Portland, Portland, Oreg.; Portland State University, Portland, Oreg.
Social work student (master's)	3	Montana State Department of Public Welfare, Helena, Mont.; Portland State University, Portland, Oreg.
Radiologic technologist trainee	1	Oregon Institute of Technology, Klamath Falls, Oreg.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
NEW PROGRAMS						
Occupational therapist student	0	$3, 250	$9, 881	0	0	2
Physical therapist student	0	3, 250	9, 881	0	0	2
Occupational therapist assistant trainee	0	4, 621	9, 881	0	0	2
Pharmacy student	0	8, 098	0	0	0	2
Medical technician student	0	2, 249	0	0	0	2
Radiologic technologist trainee	0	2, 249	0	0	0	2
Orthopedic-prosthetic trainee	0	4, 621	0	0	0	2
Total	0	28, 338	29, 643	0	0	14

WALLA WALLA, WASH.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Basic nursing student	102	Walla Walla College, College Place, Wash.; Walla Walla Commercial College, Walla Walla, Wash.
Professional nurse trainee	11	Walla Walla Commercial College, Walla Walla, Wash.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space	Other costs	Number of additional and new trainees
NEW PROGRAMS						
Occupational therapist student	$6,000	$6,000				1
Pharmacy technician	6,000	6,000				1
Personnel management specialist trainee	10,000	10,000				1
Engineering officer trainee	9,881	9,881				1
Building management trainee	6,548	6,548				1
Medical administration division trainee	8,098	8,098				1
Grand total	46,527	46,527				6

BECKLEY, W. VA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Certified laboratory assistant trainee	12	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructor salaries	Space modification	Other costs	Number of additional and new trainees
EXPANDABLE PROGRAMS						
Certified laboratory assistants	$21,672	$5,080	$15,392	0	$1,200	4
Total	$21,672	5,080	15,392	0	1,200	4

CLARKSBURG, W. VA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	13	
Dental intern (noncareer)	1	
Medical student 1st 2 school years	63	West Virginia University School of Medicine, Morgantown, W. Va.
Medical student 2d 2 school years	25	Do.
Basic nursing student	87	West Virginian Wesleyan College, Buckhannon, W. Va.
Psychology student (graduate)	5	West Virginia University, Morgantown, W. Va.
Social work student (master's)	4	Do.
Hospital librarian student	2	West Virginia Wesleyan College, Buckhannon, W. Va.
Personnel management specialist trainee	1	
Medical secretary	1	Salem College, Salem, W. Va.

CLARKSBURG, W. VA.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed: Total	Stipends	Instructors salaries	Space	Other costs	Number of trainees
EXPANDABLE PROGRAMS						
Social work students	$40,800	$27,000	$12,000	$1,800	0	8
NEW PROGRAMS						
Dental assistant	30,000	12,000	15,000	1,000	$2,000	4
Practical nurse trainee	75,000	50,000	20,000	0	5,000	20
Professional nurse trainee	10,000	0	10,000	0	0	4
Nursing assistant trainee	62,000	40,000	20,000	0	2,000	20
Occupational therapy assistant trainee	2,600	2,500	0	0	100	1
Physical therapy assistant trainee	2,600	2,500	0	0	100	1
Pharmacy student	6,000	6,000	0	0	0	1
Pharmacy assistant trainee	2,600	2,500	0	0	100	1
Dietetic student	6,200	6,000	0	0	200	3
Food service worker trainee	12,200	12,000	0	0	200	6
Medical technical student	5,400	5,900	0	0	400	
Laboratory assistant trainee	10,400	10,000	0	0	400	
Autopsy Assistant trainee	2,900	2,500	0	0	400	2
Hospital library work study	6,000	6,000	0	0	0	4
Medical Records Technician trainee	3,000	3,000	0	0	0	1
EKG tech trainee	2,600	2,500	0	0	100	1
Cardiopulmonary Technician trainee (general)	3,100	3,000	0	0	100	2
Surgery technical trainee (general)	3,100	3,000	0	0	100	1
Hospital administrative resident	6,200	6,200	0	0	0	1
Graduate engineering trainee	9,000	9,000	0	0	0	1
Personnel management trainee	7,000	7,000	0	0	0	1
Accountant trainee	8,200	8,200	0	0	0	1
Building management trainee	7,000	7,000	0	0	0	1
Laundry Superintendent trainee	8,800	8,800	0	0	0	1
Total	291,900	214,700	65,000	1,000	11,200	80
Grand total	332,700	241,700	77,000	2,800	11,200	88

HUNTINGTON, W. VA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	4	
Dental resident (noncareer)	2	
Dental assistant trainee	1	Southwestern Community Action, Inc., Huntington, W. Va.
Audiology and speech pathology student (master's).	1	Marshall University, Huntington, W. Va.
Social work student (master's)	10	West Virginia University, Morgantown, W. Va.

MARTINSBURG, W. VA.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	2	
Basic nursing student	20	West Virginia Wesleyan, Buckhannon W. Va.; Kings Daughters Hospital, Martinsburg, W. Va.
Practical nurse student	23	James Rumsey Vocational Technical Center Martinsburg, W. Va.
Professional nurse trainee	6	
Medical student 1st 2 school years	2	George Washington University School of Medicine, Washington, D.C.
Audiology and speech pathology student (master's).	4	West Virginia University, Morgantown, W. Va.
Psychology student (graduate)	6	Catholic University, Washington, D.C.; University of Maryland, College Park, Md.; West Virginia University, Morgantown, W. Va.; American University, Washington, D.C.
Corrective therapist student	1	Shepherd College, Shepherdstown, W. Va.
Pharmacy intern	2	West Virginia University, Morgantown, W. Va.
Medical technologist student	5	Shepherd College, Shepherdstown, W. Va.
Personnel management specialist trainee	1	
Accountant trainee	1	
Supply management trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Audiology speech pathology student	$23,345	$6,440	$11,905	$5,000		2
Corrective therapist student	1,064				$1,064	5
Pharmacy intern	17,979	8,098	9,881			1
Medical technologist student	18,628	6,747	9,881	2,000		3
Total	61,016	21,285	31,667	7,000	1,064	11
NEW PROGRAMS						
Basic nursing student						23
Social work student	17,361	5,980	9,881	1,500		2
Physician's assistant	1,582				1,582	2
Total	18,943	5,980	9,881	1,500	1,582	27
Grand total	79,959	27,265	41,548	8,500	2,646	38

MADISON, WIS.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	102	
Medical intern	44	
Career pathology resident	1	
Medical student 1st 2 school years	102	University of Wisconsin Medical School, Madison, Wis.
Medical student 2d 2 school years	198	Do.
Basic nursing student	198	University of Wisconsin, Madison, Wis.; Madison General Hospital, Madison, Wis.
Practical nurse student	146	Madison Area Technical College, Madison, Wis.
Psychology student (graduate)	1	University of Wisconsin, Madison, Wis.
Physical therapist student	40	Do.
Pharmacy resident	2	Do.
Dietetic intern	12	Do.
X-ray technician trainee	16	Do.
Electrocardiograph technician trainee	1	Do.
Research and education trainee	1	Do.

MADISON, WIS.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Social work student	$21,946.45	$8,970.00	$12,976.45	-----------	$500	3
Physical therapist student	5,681.08	5,681.08	-----------	-----------	-----------	1
Total	28,127.53	14,651.08	12,976.45	-----------	500	4
NEW PROGRAMS						
Physician's assistant	17,653.64	17,653.64	-----------	-----------	-----------	2
Physician's assistant (pathology)	109,038.49	88,268.20	10,770.29	$5,000	5,000	10
Physical therapy assistant trainee	11,362.16	11,362.16	-----------	-----------	-----------	2
Inhalation therapy technician trainee	11,362.16	11,362.16	-----------	-----------	-----------	2
Operating room technician trainee	11,362.16	11,362.16	-----------	-----------	-----------	2
Medical technician trainee	153,403.93	44,980.00	28,423.93	50,000	30,000	20
Total	314,182.54	184,988.32	39,194.22	55,000	35,000	38
Grand total	341,810.07	199,639.40	52,170.67	55,000	35,500	42

TOMAH, WIS.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Practical nurse student	65	Western Wisconsin Technical Institute, La Crosse, Wis.
Dietetic student	2	Stout State University, Menomonie, Wis.
Medical technician trainee	2	District One Technical Institute, Eau Claire, Wis.
Graduate engineer trainee	1	

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
NEW PROGRAMS						
Dental assistant trainee	$41,013	$23,105	$8,908	$2,000	$7,000	5
Dental hygienist trainee	41,013	23,105	8,908	2,000	7,000	5
Dental laboratory technician	5,212	5,212	0	0	0	1
Psychology student predoctorate	24,294	24,294	0	0	0	3
Psychology student baccalaureate training	19,644	19,644	0	0	0	3
Social worker student, M.A. degree	21,882	21,882	0	0	0	3
Social worker student, baccalaureate training	15,636	15,636	0	0	0	3
Manual arts therapy student	11,706	11,706	0	0	0	2
Corrective therapy student	11,706	11,706	0	0	0	2
Recreation specialist student	11,706	11,706	0	0	0	2
Occupational therapy assistant trainee	10,424	10,424	0	0	0	2
Physical therapy assistant trainee	5,212	5,212	0	0	0	1
Manual arts therapy assistant trainee	10,424	10,424	0	0	0	2
Corrective therapy assistant trainee	5,212	5,212	0	0	0	1
FSW trainee	99,369	85,488	9,881	2,000	2,000	15
Hospital librarian work study trainee	5,212	5,212	0	0	0	1
X-ray technician trainee	5,212	5,212	0	0	0	1
EKG technician trainee	5,212	5,212	0	0	0	1
P.M. & R. coordinator trainee	6,548	6,548	0	0	0	1
Personnel management specialist trainee	6,548	6,548	0	0	0	1
Building management officer trainee	6,548	6,548	0	0	0	1
Laundry superintendent trainee	6,302	6,302	0	0	0	1
Supply management trainee	6,548	6,548	0	0	0	1
Medical administration trainee	6,548	6,548	0	0	0	1
Director voluntary service trainee	6,548	6,548	0	0	0	1
Total	395,679	345,982	27,697	6,000	16,000	60

WOOD, WIS.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Medical resident (noncareer)	208	
Medical intern	15	
Career psychiatry resident	3	
Career anesthesiology resident	2	
Dental resident (noncareer)	6	
Dental intern (noncareer)	4	
Career dental resident	5	
Medical student 1st 2 school years	113	Marquette School of Medicine, Milwaukee, Wis.
Medical student 2d 2 school years	185	Do.
Dental assistant trainee	16	Milwaukee Area Technical College, Milwaukee, Wis.
Dental laboratory technician trainee	3	Do.
Basic nursing student	247	Milwaukee Area Technical College, Milwaukee, Wis.; Alverno College, Milwaukee, Wis.; Marquette University, Milwaukee, Wis.; University of Wisconsin, Milwaukee, Wis.; Waukesha County Technical Institute, Waukesha, Wis.
Graduate nursing student	4	Marquette University, Milwaukee, Wis.
Practical nurse student	60	Milwaukee Area Technical College, Milwaukee, Wis.; Waukesha County Technicial Institute, Waukesha, Wis.
Audiology and speech pathology student (master's).	2	University of Wisconsin, Milwaukee, Wis.
Psychology student (graduate)	27	University of Wisconsin, Madison, Wis.; University of Wisconsin, Milwaukee, Wis.; University of Arizona, Tucson, Ariz.; University of Southern Illinois, Carbondale, Ill.
Psychology student (postdoctoral)	2	University of Wisconsin, Milwaukee, Wis.; University of Texas, Austin, Tex.
Vocational rehabilitation counselor student	4	University of Wisconsin, Milwaukee, Wis.
Social work student (master's)	6	Do.
Occupational therapist student	11	University of Wisconsin, Madison, Wis.; Mount Mary College, Milwaukee, Wis.; Indiana University, Indianapolis, Ind.
Physical therapist student	26	University of Wisconsin, Madison, Wis.; Marquette University, Milwaukee, Wis.
Pharmacy intern	1	University of Wisconsin, Madison, Wis.
Dietetic student	5	Stout State University, Menomonie, Wis.
Medical technologist student	31	St. Norbert's College, Depere, Wis.; Wisconsin State University, Oshkosh, Wis.; Mount Mary College, Milwaukee, Wis.; University of Wisconsin, Milwaukee, Wisc.; Marquette University, Milwaukee, Wis.; Wisconsin State University, Whitewater, Wis.
Histologic or histopathology technician trainee	8	Marquette University, Milwaukee, Wis.
Hospital librarian work-study trainee	1	University of Wisconsin, Milwaukee, Wis.
Radiologic technologist trainee	18	
Radiation therapy technologist trainee	7	
X-ray film processor trainee	1	
Medical record librarian trainee	2	
Inhalation therapy technician trainee	6	Mount Sinai Hospital, Milwaukee, Wis.
Medical student anesthesiology trainee	7	Marquette School of Medicine, Milwaukee, Wis.
Electrocardiograph technician trainee	1	
Nuclear medicine technician trainee	2	
Research and education trainee	2	Do.

WOOD, WIS.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Dental assistant trainee	$128, 320		$58, 320	$50, 000	$20, 000	16
Dental laboratory technician trainee	29, 440		19, 440		10, 000	4
Audiology and speech pathology student (M.A.)	114, 120	$7, 000	42, 120	45, 000	20, 000	4
Social work student (M.A.)	48, 780	18, 000	30, 780			10
Social work student (B.A.)	14, 040		14, 040			8
Pharmacy intern	18, 000	18, 000				2
Radiologic technician trainee	65, 920	40, 000	25, 920			15
Inhalation therapy technician trainee	20, 800		10, 800		10, 000	5
Nuclear medicine technician trainee	30, 240		30, 240			4
Total	469, 660	83, 000	231, 660	95, 000	60, 000	68
NEW PROGRAMS						
Dental hygienist trainee	7, 560		7, 560			4
Pharmacy assistant trainee	20, 000	20, 000				1
Medical record technician trainee	6, 400	6, 000			400	
Cardiopulmonary technician trainee	58, 420	27, 500	25, 920	5, 000		5
Graduate engineering trainee	9, 000	9, 000				1
Hospital plant operator trainee	8, 000	8, 000				1
Medical equipment technician trainee	21, 600		21, 600			6
Total	130, 980	70, 500	55, 080	5, 000	400	22
Grand total	600, 640	153, 500	286, 740	100, 000	60, 400	90

CHEYENNE, WYO.

I. FISCAL YEAR 1970

Category of training program	Number of trainees	Cooperating institutions
Radiologic technologist trainee	16	School of X-Ray Technology, Pershing Memorial Hospital, Cheyenne, Wyo.
Operating room technician trainee	1	Laramie County Community College, Cheyenne, Wyo.
Medical secretary	3	Do.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Nursing assistant trainee	$23, 105	$23, 105	0	0	0	5
Radiologic technologist	1, 284	1, 284	0	0	0	1
Total	24, 389	24, 389	0	0	0	6
NEW PROGRAMS						
Social work student	2, 990	2, 990	0	0	0	1
Physical therapist student	3, 250	3, 250	0	0	0	1
Medical technologist student	2, 249	2, 249	0	0	0	1
Total	8, 489	8, 489	0	0	0	3
Grand total	32, 878	32, 878	0	0	0	9

SHERIDAN, WYO.

I. FISCAL YEAR 1970

Training program	Number of trainees	Cooperating institutions
Dental hygienist trainee	20	Sheridan College, Sheridan, Wyo.
Dental laboratory technician trainee	1	Do.
Psychology student (master's)	5	University of Wyoming, Laramie, Wyo.
Clinical social science student	3	Do.

II. POTENTIAL EXPANSION BY SEPTEMBER 1971

Training program	Additional dollars needed					Number of additional and new trainees
	Total	Stipends	Instructor salaries	Space	Other costs	
EXPANDABLE PROGRAMS						
Dental laboratory technician trainee	$31,200	$16,200		$10,000	$5,000	6
Total	31,200	16,200		10,000	5,000	6
NEW PROGRAMS						
Basic nursing student	71,905	60,000	$11,905			30
Social work student (doctoral)	10,548	4,000	3,548	2,500	500	2
Social work student (master's)	5,000	2,000		2,500	500	2
Social work student (baccalaureate)	4,350	1,600		2,500	250	2
Social science student trainee	2,000	2,000				1
Mental health associate trainee	38,300	28,800	5,000		4,500	32
Psychology undergraduate students	17,136	17,136				12
Total	149,239	115,536	20,453	7,500	5,750	81
Grand total	180,439	131,736	20,453	17,500	10,750	87

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